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THE CHAS. T. MILLER HOSPITAL, ST. PAUL, MINN.

By STIRLING HORNER, OF THE STAFF OF C. H. JOHNSTON, ARCHITECT, ST. PAUL, MINN.

WHEN the board of trustees of the Charles T. Miller Hospital announced the purchase of an irregular tract of land lying between Summit and College Avenues and extending through on a third side to Rice Street, three thoroughfares of quite different elevations and grades, a complex and unusual problem of hospital planning was presented for architectural study.

After some weeks of careful study, involving problems of administration, orientation, traffic, topography of site, and approachability, it was thought advisable to place the main façade and entrance on College Avenue, a street of somewhat less importance, perhaps, than Summit Avenue, but having a considerable lower elevation. College Avenue carries materially less traffic than Summit, and the cars of visiting physicians and others offer no impediment, a condition which might be very burdensome at times on the busier avenue.

The difference in street elevations seemed at once to declare for an administrative, interns',

and service floor at College Avenue elevation, with the first typical ward and patients' floor slightly above the Summit Avenue elevation on the northwest side of the property. The existing topography, with the ground falling away sharply to the southwest made possible an ambulance entrance to the first floor in the southwest court, with a driveway extending clear through the block, a service entrance and driveway in the northeast court at ground floor grade, and nurses' entrance on the Summit Avenue side slightly above grade. This location for the building left the level tract on the northwest available for the contemplated children's hospital and nurses' residence, without which the group is incomplete.

When the plans had reached this stage of development, the Amherst H. Wilder Charities, whose directorate was partially interlocked with that of the Miller Hospital, began negotiations which culminated in the purchase of adjoining property upon which it is planned to erect a free dispensary and out-patients' clinic,



The entrance of the Charles T. Miller Hospital, St. Paul, Minn.



The foyer of the hospital.

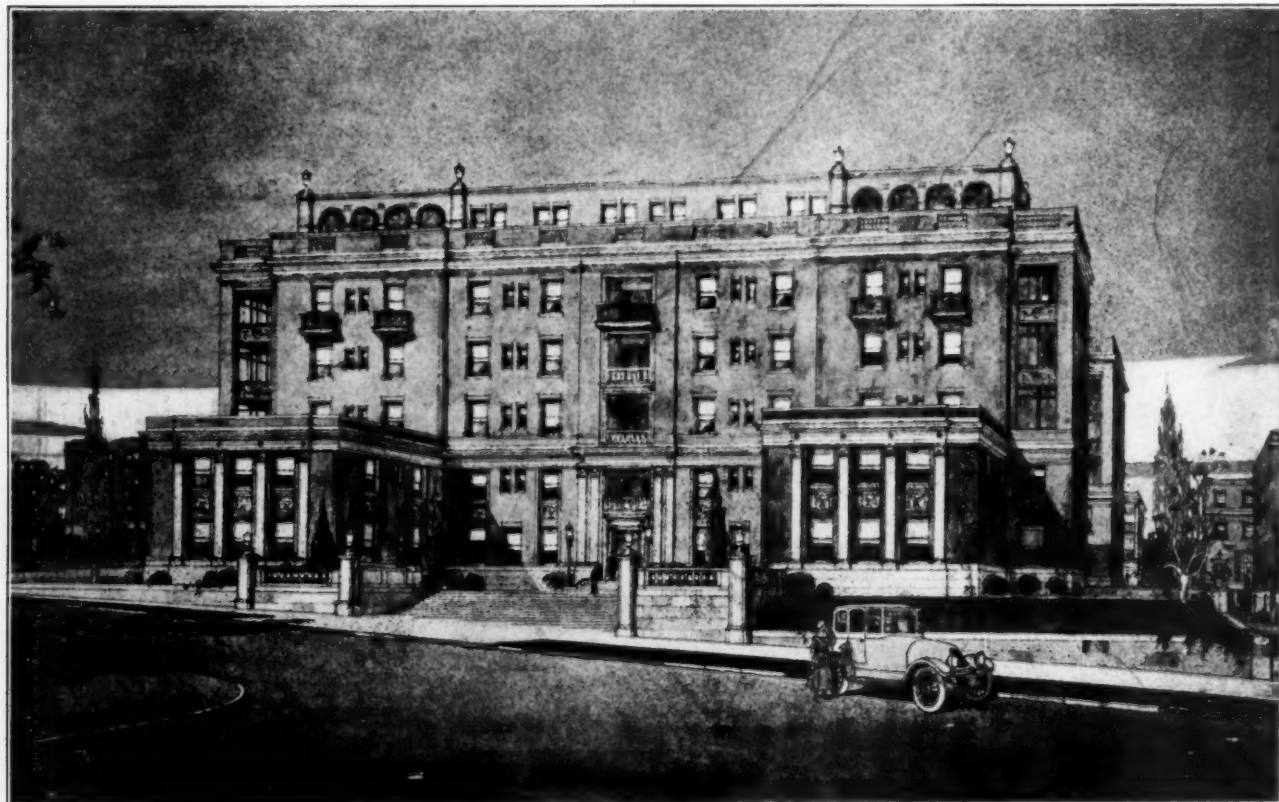
operated in conjunction with and by the staff of Miller Hospital, with which it is to be connected by subway.

The hospital accommodates two hundred and sixteen patients. There are fifty free beds disposed in one, two, four, and six-bed wards. All other patients are in private rooms, each having individual toilet and lavatory accommodation, and in most cases, baths. The rooms throughout have been attractively furnished, avoiding so far as possible the cheerless white enameled furniture of the stereotyped hospital room.

The north wing of the fourth floor provides for the operating section, obstetric rooms, and laboratories. The operating suite, with five operating and the necessary accessory rooms, completely supplied with all modern surgical equipment and appliances, occupies the north end of the wing, with the delivery, wash-up, sterilizing rooms, and nursery at the opposite end of the corridor. The nursery has been made a part of this section to avoid the attendant noise disturbing the maternity patients in the south wing. This departure from the usual placing of the crèche in close proximity to patients' rooms is proving very satisfactory and practicable.

In general, the diet kitchens and service rooms on each floor have been grouped in the central portion of the building, accomplishing ease of food distribution, convenience in handling cases requiring surgical dressings, and special facilities for examinations. A feature of this group of rooms is the inclusion on each floor of a small room where flowers are received and arranged before being taken to the patient, and where they are stored for the night also.

The main passenger elevator extends to the roof house. The major portion of the roof scheme is as yet unfinished, but this space will eventually be reclaimed for convalescent porches, recreational spaces, and for the outdoor care of suitable cases.

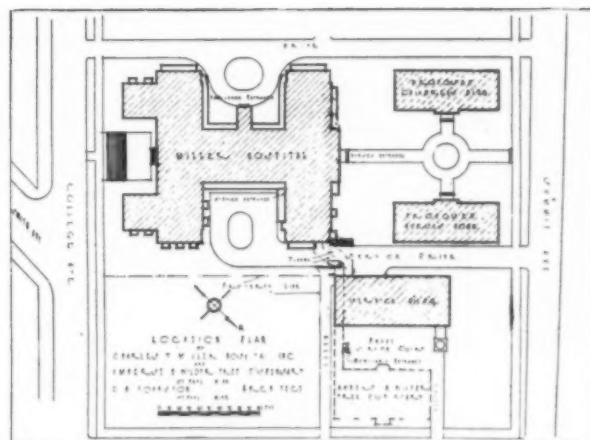


An exterior view of the hospital.

The handling of kitchen stores is planned much on the principle employed in large modern hotels. All stores are received, checked, and stored by the steward, and issued on daily requisition. A freight elevator connects the receiving lobby with the basement storerooms and a large root cellar conveniently placed under the service driveway. The general diets are taken in fireless cooker conveyors to the diet kitchens on each floor, from which they are served directly to the patient. Special diets are prepared in the dietetic kitchen on the first floor and served directly therefrom via electric elevators. The entire basement story is of the same general height as the typical floors. It is occupied at present only in part by stewards' storerooms, hospital storerooms, and a complete x-ray department.

The power plant and laundry are housed in a separate structure adjoining the main building on the north, and connected with it by both pipe and service tunnels. The hospital group is heated by means of Webster two pipe vacuum system making use of the exhaust steam from the engine units. This first winter of operation has demonstrated the practicability of this installation. Perfect circulation has been maintained with from one to two inches of vacuum on the mains. The boiler room is equipped with two 250 horsepower Connolly water tube boilers served with type E stokers and vacuum ash conveyors. The pump room contains vacuum, boiler feed water, and service pumps, feed water and domestic water service heaters. Power is obtained from two Ridgeway four valve engine generator units of 150 and 75 K.V.A. capacity, with selective turbine or motor driven excitation.

The switchboard comprises the usual arrangement of generator, exciter and service panels, including Bristol strip recording wattmeter, for both light and power loading, and an integrating



The location plan of the Charles T. Miller Hospital and the Amherst H. Wilder Free Dispensary.

wattmeter on the totalizing panel.

Complete duplication of units for breakdown service is installed. The switchboard is also connected with the central power company's service for night use when the plant is operating under a light load. A complete installation of indicating and recording meters, coal scales, indicating draft gauge, CO₂ meter, indicating pyrometer, and Venturi meter give the chief engineer a complete check on boiler performance. All toilets, utility rooms, serving rooms, kitchen and operating suites are mechanically ventilated. Vacuum cleaning facilities are provided for the entire group.

The second floor of this building is entirely occupied by a completely equipped laundry connected with the service tunnel by an automatic elevator. Plumbing fixtures throughout are of porcelain or vitreous china. Lighting fixtures in patients' rooms are fully enclosed, dust proof, indirect units with two lamps controlled on separate switches for either regular or dim illumination. A silent nurses' call system is in use, with



The attractive kitchen of the hospital.



The switch board of the power plant.

annunciators installed in specially constructed nurses' desks located at corridor intersections. The switches for the staff register are located in the corridor outside the doctors' coat room, with



The power house and laundry connected with the hospital.

the register board directly above the telephone switchboard in the main office. This arrangement has proved of great convenience in connection with the musalophone, as incoming calls for physicians in the building are cared for by the telephone operator without leaving her position.

Glass enameled, flushing clothes chutes open into soiled linen closets on each floor and into a large room in the basement in which the linen is sorted and examined before being trucked through the tunnel to the laundry. Adjoining the soiled linen room, in the basement, a sterilization unit is installed for the disinfection of bedding and patients' clothing. The kitchen, serving, and utility rooms and the mortuary in the service building are equipped with built-in porcelain enameled refrigerators chilled with a circulating brine system.

The group of buildings is designed in Renaissance style, executed in red colonial brick and Bedford limestone. The buildings have been made completely fireproof by using a reinforced concrete skeleton type of construction.

Serving room and corridor floors and stairways are of terrazzo. All utility rooms, private toilet rooms, and operating rooms have tile floors with glazed tile wainscots. The public toilets have tile floors and marble wainscots. The entire kitchen and service section, including corridors, has tan colored salt glazed brick wainscots, with red quarry tile floors. Patients' rooms have wood floors and walnut stained birch trim. Operating rooms, toilets, and utility rooms are in gray enamel.

The plans for the service building contemplate

two additional stories, housing male and female domestic servants. Future growth of the institution will necessitate the addition of a children's hospital and nurses' residence on the Summit Avenue side of the property.

No description of this hospital plant is complete without reference to the efficient organization which has been brought together by the superintendent, Dr. Louis B. Baldwin, under whose directions the plans were prepared and to whom the architect is indebted for many helpful suggestions during their perfection.

HEALTH AGENCIES TO BE HOUSED UNDER ONE ROOF

Arrangements have been made by a "Common Service Committee" representing the American Social Hygiene Association, the National Committee for Mental Hygiene, the National Organization for Public Health Nursing, and the National Tuberculosis Association, for two floors of the new Penn Terminal Building at 370 Seventh Avenue, New York City, to house the executive and office staffs of several health agencies. These agencies are: The American Public Health Association, American Social Hygiene Association, Bureau of Social Hygiene, National Child Health Organization, National Health Council, National League for Nursing Education, National Organization for Public Health Nursing, National Tuberculosis Association, and a branch office of the United States Public Health Service.

The American Society for the Control of Cancer, the Health Service Department, the New York Chapter of the American Red Cross, and other organizations are considering moving to the same building.

Efficient and economical administration of these activities will be promoted by this arrangement, for, though each organization will retain its own independence, there are certain things, such as storage, distribution of materials, telephone, rest room, library facilities, etc., which can be carried on in common. Further plans for cooperation are now being considered by the National Health Council.

DR. PONTON TO SURVEY CANADIAN HOSPITALS

Dr. T. R. Ponton of the Vancouver General Hospital, Vancouver, B. C., recently began a survey for the American College of Surgeons of all the hospitals in the Dominion of Canada of fifty beds and over. Dr. Ponton will make this survey in one continuous trip, starting from Vancouver and working east. The survey will probably take about four months.

Five physicians on the staff of the American College of Surgeons are now surveying the hospitals located in the United States, giving particular attention to the hospitals of 100 beds and over that are not on their 1920 approved list. Hospitals with a bed capacity of from fifty to 100 beds located on the itinerary of these men are also being visited. The results of these inspections will be published in the American College of Surgeons' 1921 list of approved hospitals.

The Hospital Library and Service Bureau has found its list of architects connected with the hospital field to be so successful that it is compiling a list of landscape architects who have done institutional work.

THE FINANCIAL CAMPAIGN AS A METHOD OF RAISING MONEY FOR HOSPITALS

By MARY FRANCES KERN, DIRECTOR OF FINANCIAL CAMPAIGNS, CHICAGO, ILL.

FEW American communities have an adequate number of hospital beds. In some, therefore, new hospitals need to be built; in others, existing hospitals need to be enlarged and more completely equipped. To meet these requirements, funds are of course needed. How are they to be secured? One of the methods, to be described briefly here, is the method of the financial campaign, or, as it came to be known during the war, the "drive." In most instances this method has been found successful, especially when the campaign was conducted by a thoroughly qualified director.

The fund-raising campaign has been developed through various stages into a definite business. Institutions such as schools, colleges, universities, hospitals, sanatoriums, homes for the aged and orphans, and welfare centers now consult with campaign experts just as they consult with attorneys, expert accountants, advertising agents, or other specialists. This has come about through the demand for competent executives who have devoted their time and talent to intensive study of organization and financial appeal. With the five great liberty loans in mind, it is easy to fall into the error of thinking that financial campaigns were the outgrowth of the World War, and to forget that campaigns of this character were conducted successfully long before 1914.

In undertaking a financial campaign, one of the most important steps is the selection of the campaign director. Many of the qualifications for this position are obvious, but above all he must be a person of experience and absolute integrity. To put a hospital financial campaign in the hands of an inexperienced director is to run grave chances of failure. Promotional concerns interested solely in securing contracts, offer many roseate promises and point proudly to their carefully worked out plans. This is dangerous on its face, for a campaign must have an individuality and a distinction of its own based on a careful study of the needs of the community and of the sources from which support is to be drawn. If a director lacks the experience and training necessary to apprehend these differences, the campaign is likely to become an unhappy fiasco.

With the pledged cooperation of all the friends of the hospital, and a staff of seasoned executives to conduct the campaign, the hospital's chances of success are good.

Procuring funds, you will discover, is only a part of the benefit to be derived from the campaign. In a well-conducted drive the hospital will win many staunch supporters, and build up a backing, the value of which is often greater than the money secured through the campaign. The head of a prominent hospital, in commenting on a successful campaign through which his institution had just passed, said, "The value of a drive in reviving interest in the hospital and in making new friends for it is incalculable. I would much rather have \$500,000 from 50,000 men and women than \$1,000,000 from a few hundred wealthy patrons."

By your effort, the public is educated through campaign publicity. It learns what you have achieved in the past and what you desire to do in the future. It learns the importance to the community of a modern, well conducted hospital. It tends to overcome the impressions of many intelligent, but ill informed people, that the hospital is a place to which their friends may be taken only in extreme need.

Under the stimulus of the campaign, the already existing hospital is apt to undergo a thorough house cleaning, even though the headquarters of the campaign are away from the institution itself. Shortcomings in organization, in administration, and in equipment are brought to light and the effect of the searching scrutiny of all departments is unquestionably beneficial.

In short, the effect of a campaign on the community is best described in an editorial which appeared in a Middle Western daily recently, at the close of a successful hospital financial campaign. The editorial runs in part as follows: "The campaign raised the dormant enthusiasm in community spirit in this county, which has been hitherto undeveloped, and in fact, it is our belief that the effort along this line is actually of more importance to the whole district than the \$300,000 which was raised for our hospital; . . . not only was this community left a hospital, but also a stimulus to encourage the people here to do big things, things which before seemed impossible."

As has already been pointed out, conducting financial campaigns is a business, and every phase of the campaign should be businesslike. In the first place, the directing organization should be employed at a definite salary. In the early days, campaign directors were employed on a percent-

age basis, and many people refused to contribute because they did not wish to see part of their subscription go to promotion. This reason for refusing to give no longer rings true, for all of the expenses of the drive under the new method are underwritten in advance by the hospital board of directors, or by an interested group of citizens. One hundred cents of every dollar subscribed goes to the hospital.

In the second place, all disbursements of the campaign should be passed upon by a finance committee and at the close of the campaign an auditor should examine the committee's books and make a public report. In this way every cent expended by the directing staff is accounted for to the trustees, or whatever group of citizens underwrites the expenses of this campaign.

In the third place, an auditor should be em-

ployed to receive all moneys collected during the campaign. He should keep an accurate account of all receipts and at the close of the campaign turn the funds over to the hospital authorities.

In the light of results, the cost of a well conducted, businesslike financial campaign should be extremely low. For example, a campaign for a goal of \$300,000, which terminated this year, came to a successful conclusion at a total cost of less than 3.5 per cent. It is believed that within the year the efforts put forth in this campaign will bring the hospital nearly half a million dollars, making the total cost about 2 per cent. Conditions vary, however, and the cost of raising the funds in some communities will run higher. Yet 5 or 6 per cent is merely the interest on the desired fund for one year and you have no principal or further interest to meet.

THE NEW CHILDREN'S BUILDING OF THE NATIONAL JEWISH HOSPITAL FOR CONSUMPTIVES

BY MRS. S. PISKO, SECRETARY, NATIONAL JEWISH HOSPITAL FOR CONSUMPTIVES, DENVER, COLO.

EIGHT decades ago George Bodington, a country practitioner of Warwickshire, England, established in Sutton, the first sanatorium in the world based upon the use of a generous diet, fresh air day and night, and careful medical supervision for consumptives. He had been effecting cures for several years when he published his results, whereupon there arose a bitter and

efforts of Brehmer and his supporters that the value of the open-air treatment of tuberculosis was finally established. In America, Edward L. Trudeau was eager to test the methods of Brehmer, and in 1884, after having himself benefited by the open-air treatment in the Adirondacks, the "Trudeau Sanatorium" was started. A beginning was made with small donations, a few acres of land, and two small buildings. This was the pioneer sanatorium of America and has set the example for the establishing in this country of a large number of private and public sanatoriums for the treatment of all stages of tuberculosis. In France, more than any other country, the efforts were directed toward combating the disease



Front view of the Hofheimer Children's Building of the National Jewish Hospital for Consumptives.

contemptuous opposition to his views and he was compelled to abandon his work. Fourteen years later, in 1854, Herman Brehmer, being attracted by the ideas of the English doctor, succeeded in spite of ridicule and opposition in founding his sanatorium, which was opened in 1859, at Goerbersdorf in Prussian Silesia. It was through the



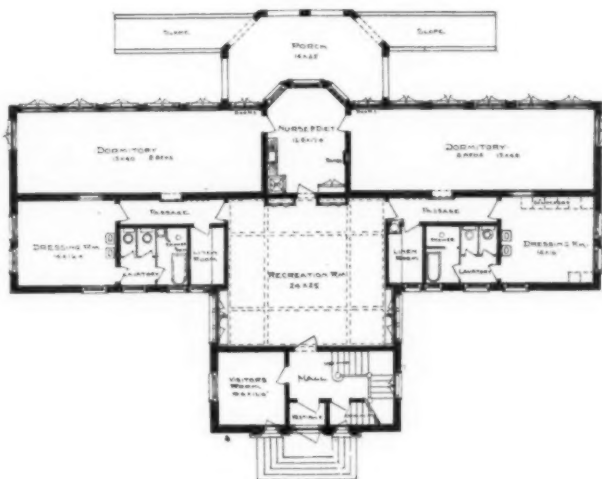
Rear view of the Hofheimer Children's Building of the Memorial Jewish Hospital for Consumptives.

in childhood. In 1888 there was founded by private initiative, a society called "L'Oeuvre des In-

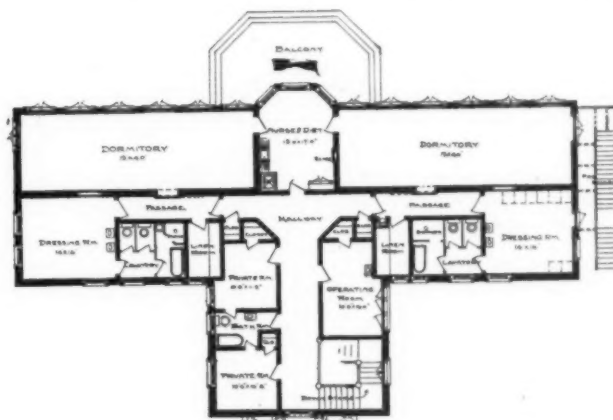
fants Tuberculeuse," which was recognized as a public utility by a decree of the French Government in 1894. Their hospitals of Ormesson and of Villiers admit consumptive children in every stage. At Davos in Switzerland, one of the most famous sanatorium centers in the world, is situated Dr. Turban's sanatorium opened in 1887. Here has been established a class of "Prophylactiker" made up of children of consumptive parents, who are educated, physically and mentally, so that they may avoid the disease of their parents.

The National Jewish Hospital for Consumptives of Denver, Colo., was established in 1899, as a sanatorium for tuberculous patients who are unable to pay. Starting with a single building, "A monument of deeds, one that marks no creeds," and supported entirely by Jewish philanthropy, it has gradually grown to dimensions comparable to the best sanatoriums in the United States. Its achievements have been a pride to the Jews of America, and its success had "added another to the great monuments that have marked the liberality of the Jewish people through all ages." There is no charge to patients who enter the hospital. "None may pay who enter, none may enter who can pay." Admittance to the hospital is arranged through local organized charity. Patients are admitted from all parts of the United States.

The following list gives the source of the 3,613 patients treated since 1900:



Plan of the first floor of the children's building.



Plan of the second floor of the children's building.



An artistic dining room, such as this one, adds much to the enjoyment as well as the healthfulness of one's meals.

Alabama	59	Illinois	535
Arizona	14	Indiana	64
Arkansas	29	Iowa	29
California	144	Kansas	12
		Kentucky	104
		Louisiana	35
		Maine	4
		Maryland	29
		Massachusetts	72
		Michigan	52
		Minnesota	101
		Mississippi	14
		Missouri	264
		Montana	0
		Nebraska	64
		Nevada	0
		New Hampshire	0
		New Jersey	107
		New Mexico	15
		New York	1030
		North Carolina	5
		North Dakota	1
		Ohio	385
		Oklahoma	10
		Oregon	6
		Pennsylvania	182
		Rhode Island	13
		South Carolina	4
		South Dakota	1
		Tennessee	58
		Texas	77
		Utah	4
		Virginia	28
		Wisconsin	50
		Washington	11
		West Virginia	5
		British Columbia	1
		Canada	10
		England	1
		Ireland	2
		Russia	7
		Scotland	2
		Not stated	5
Colorado	95		
Connecticut	54		
Delaware	3		
District of Columbia	6		
Florida	12		
Georgia	21		
Idaho	4		

Of the 3,613 patients treated since 1900, 50 per cent have returned to their former occupations, either cured or greatly improved. The following is an itemized list of the results obtained: recovered, 716; greatly improved, 1,337; slightly improved, 543; unimproved, 857; died, 160.

The National Jewish Hospital is located in Denver, a city high above the sea, in the immediate vicinity of the wonderful Rocky Mountains, where the air is clear and dry, and the sun shines nearly every day of the year.

Eleven buildings house the hospital. In addition, there is a seventy acre farm to furnish a daily supply of fresh milk and eggs. It has been with the same philanthropic spirit which has actuated the management of this institution from its inception, that the hospital has recently acquired a new children's building, the gift of Mr. and Mrs. Nathan Hofheimer, of New York. This will greatly facilitate the program of preventive



This spick and span room shows how, in a small building, economy of space may be effected by a combination diet kitchen, drug station, and chart room.

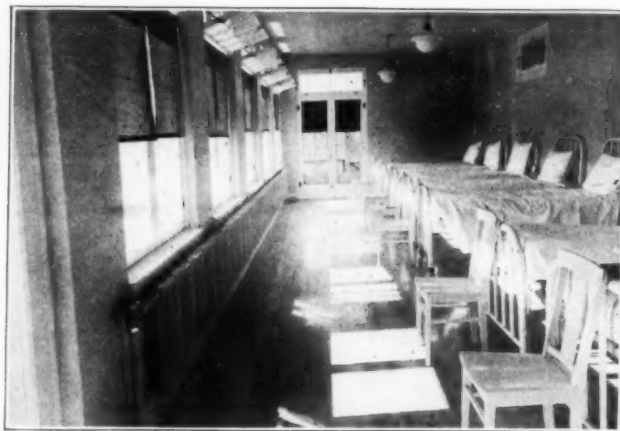
therapy which has heretofore been carried on in annexes to other buildings. The purpose of this building is to offer facilities for the children of poor tuberculous parents—a class of Turban's "Prophylactiker"—and for those suffering from the ravages of tuberculosis. The building has been planned both for efficiency and economy. It is a two story red brick building with a basement and it has a capacity of thirty-six beds. On the first floor is a reception room, a dining and play room for the children, a diet kitchen, dormitories for sixteen beds, with adjacent dressing rooms, bath rooms, toilets, linen room and pantry, and a large porch, fourteen by twenty-five feet, in which it is contemplated to apply heliotherapy. On the second floor are dormitories for sixteen beds, with adjacent dressing rooms and bath rooms, two private rooms with a private bath room for isolation purposes, a small operating room, nurses' room, linen room, and large porch. Heat, light, and hot water are supplied by the central power plant. A special feature of the building is the dormitories. These face the south, and by reason of the large number of windows and transoms are practically open air sleeping porches.



This is a well arranged nurses' room.

The purpose of the building is to establish a preventorium for children who would otherwise live in an environment that would render them susceptible to tuberculosis. They may be sent here for a variable period to be built up by the natural agents of fresh air, good food, and adequate rest, and made strong enough to hold their own in the social complex of city life. In addition it is intended to care for a certain number of orthopedic cases in this building. There are ample facilities in the Grabfelder Medical Building of the hospital to offer every diagnostic and therapeutic agent that a case may call for. In this building, which is adjacent to the children's building, there are complete facilities for all laboratory, roentgenological, and fluoroscopic examinations, in addition to special dental and nose and throat clinics.

Each child is examined fully, upon admittance, and thereafter at regular periods to determine its



The radiation, ventilation by transoms, indirect lighting, and abundance of sunlight are interesting points in this girls' dormitory.

progress. The medical care of the children is under the immediate supervision of specialists in orthopedics, pediatrics, and tuberculosis. The diets and routine life of the children are under the supervision of a competent person. The following is the basis of the routine life of the children: 6:45-7:30, daily shower and dress; 7:30-8:00, breakfast; 8:00-8:45, housework; 8:45-12:00, school; 12:00-1:00, dinner; 1:00-3:00, rest hour; 3:00-5:00, recreation and occupational therapy; 5:00-5:30, supper; 5:30-7:15, recreation or study period.

The children attend school three hours every morning and their work is conducted by an approved public school teacher. The program corresponds as nearly as possible to that used in the city grammar schools and it is planned to accomplish one semester of work in a year. The department of occupational therapy, which provides instruction in craft work, is in charge of a compe-

tent specialist. The children are trained to be nimble with their fingers, quick with their eyes, and original in ideas. The following crafts are chiefly used: basketry, leather tooling, painting, toy making, elementary book binding, weaving and block printing. Children living in an institution are necessarily barred from many of the interests of the normal child, and the tendency is to develop habits of idleness and carelessness. Occupational work to a large extent corrects this evil and is frequently responsible for the development of a latent talent. In many cases these crafts lead directly into vocational training along some original line. Whether or not these crafts are used as a means of livelihood in the future, they at least furnish a possible avocation, and in some measure care for those hours which otherwise may easily undo the years of preventive care. Part of the function of a preventorium is to furnish content of mind through active hands, and thus lay the foundations for a useful, busy life no matter what the physical handicap may be. An appreciation of beauty, and the ability to transform that appreciation into some concrete form is a never failing source of interest and pleasure to a child, and he rapidly becomes skillful enough to make objects of real value.

Diversional therapy cares for these children temporarily confined to their beds by providing simple tasks and amusements. The recreation of the children comes also under this department,

and those activities which lead to physical fitness and future personal happiness are given utmost attention. Social activities must cooperate with all the agencies that make for physical upbuilding, and the moral growth inevitably incident to the same wholesome active life.

In this manner, with the generous aid of our numerous friends, we are the agency that takes little children from the slums and tenement districts where frequently we find them pale, anemic, undernourished, and undersized, sometimes with a dulled mentality, and gives them the things that are theirs by birthright, fresh air, wholesome food, adequate rest, and wholesome ideas. In a remarkably short time the pale cheeks take on a rosy color, the dull listless eyes become bright, the child with a backward air begins to laugh heartily, and the undersized child takes on weight. Thus in about a year's time the child is ready to return to the life of the city, but now he is prepared to survive in the struggle.

An elaborate social service follow-up system is organized to watch over these children when they must give up their places to more urgent cases. The management of the hospital insists that the homes of children accepted in the institution be reconstructed before the return of the children, and as they themselves have learned the value of cleanliness and fresh air, they take this knowledge with them not only into their own homes, but into the neighborhood.

IMPROVING THE HOSPITAL FOOD SERVICE*

BY HERBERT O. COLLINS, M.D., ST. PAUL, MINN.

THE help which will be needed in the general kitchen of a one hundred bed hospital, caring for private patients, will be a chief cook, an assistant cook, two maids, one pastry cook, a night cook, and janitor service. In the special diet kitchen there will be required two or three pupil nurses, one maid, with the assistant dietitian in charge, and janitor service.

In such an organization the assistant cook should be sufficiently experienced and competent to take the place of the cook at any time in case of absence or illness, and if she can also substitute for the pastry cook, the organization will be more efficient. In a small hospital the night cook will not be busy all night, and may be given other duties, such as starting some of the operations for the breakfast. But it should be remembered that the midnight supper, usually served

the night nurses and night employees, is equivalent to the noon meal served the day force. It should not be too light a lunch, but a substantial meal, well prepared. The night cook, for this reason, should be carefully chosen and paid sufficient salary to insure competent service.

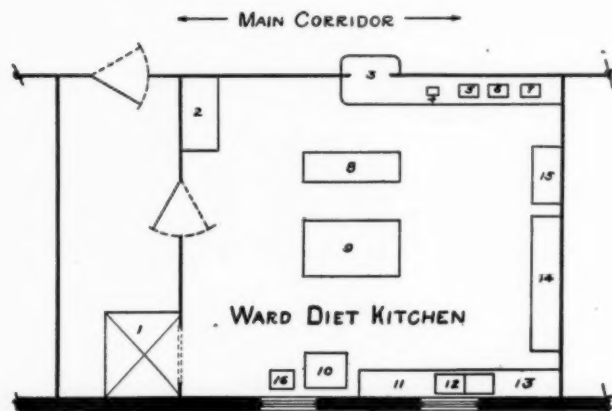
Chief Cook Head of Kitchen Force

It would be impossible, in an article of this kind, to attempt to assign the duties of the various employees in the kitchen. In many of them the titles of the positions are sufficiently descriptive, and the details will need to be left to the judgment of the one in charge. As in all efficient organizations, there must necessarily be one unquestioned head, and in the kitchen such authority will naturally be vested in the chief cook, who in his or her turn will be responsible to the dietitian. A common and successful arrangement of the work is one in which the assistant cook be-

*This is the third of a series of articles by Dr. Collins on hospital food service. The first and second appeared in the February and April issues of THE MODERN HOSPITAL.

comes largely responsible for the breakfast, the chief cook coming on duty a little later.

Subject to the approval of the dietitian, the chief cook should be held strictly responsible for ordering and receiving kitchen supplies, and for



Plan of ward diet kitchen.

- | | |
|---------------------------|--------------------------|
| 1. Food elevator. | 9. Work table. |
| 2. Refrigerator. | 10. Dish sterilizer. |
| 3. Pass window. | 11. Soiled dish counter. |
| 4. Bread cutter. | 12. Dishwashing sink. |
| 5. Hot plate. | 13. Clean dish counter. |
| 6. Toaster. | 14. Cupboard. |
| 7. Egg boiler. | 15. Dish warmer. |
| 8. Tray rack (on wheels). | 16. Shallow sink. |

their care, except those used in the special diet kitchen. This includes the care and proper use of "left-overs." For this reason, the key to the cook's supply room and to the cook's refrigerator should be in her exclusive possession. She is usually responsible for seeing that the kitchen is kept clean and neat, for the care of all apparatus and utensils, and for the department of her force. As her personal responsibility, she frequently assumes the cooking of all meats, leaving the preparation and cooking of the vegetables to the special supervision of her assistant. The maids mentioned in the list of kitchen employees need not be specially skilled in cooking. Their duties will consist mainly in preparing vegetables, washing and cleaning utensils, and some cleaning of the kitchen itself.

If properly organized, the work of the special diet kitchen will be limited to the preparation of special diets. Unless a particular room is equipped for the purpose, as is done in some of the larger hospitals, the beverages served patients between meals may be prepared here, instead of in the ward diet kitchens, with the advantage of having them made by persons specially trained in such work, with the aid of proper equipment. The preparation of desserts and salads for private patients in the special diet kitchen, as practiced in some hospitals, should be discouraged.

If there is an assistant dietitian, the special diet kitchen should be her individual responsibility, leaving the dietitian free for teaching, gen-

eral supervision, and the consideration of the larger problems of her department. The work belonging properly to the others connected with the special diet kitchen will be easily understood. The pupils nurses assigned there are employed in preparing special diets from approved or prescribed formulae, and in working out dietetic problems connected with the treatment of patients; their work in the special diet kitchen being supplemental to the theoretical teaching they receive in the class room.

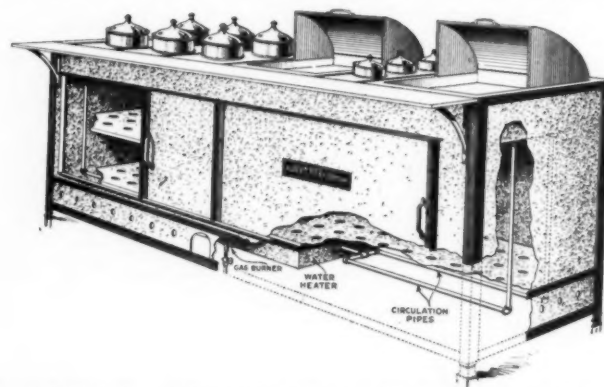
Function of the Ward Diet Kitchen

The ward diet kitchen, if more properly named, would be called the ward serving room, or pantry. Little cooking should be done in this room, as it should be reserved chiefly for the preparation of patients' trays, and the serving of food already prepared elsewhere. The food so prepared is usually sent to the ward diet kitchen in cars, which are either heated or insulated, and placed in a steam table to keep it hot while the trays are being set. A better way will be described later in this article.

A few articles of diet, which need to be specially prepared or served promptly after cooking, may be prepared here. These include such things as eggs, toast, small steaks, and in some hospitals, the cold beverages served between meals. Such work should be limited as far as possible, as it is seldom practical to obtain experienced cooks for each ward, and taking the time of the nurses in this way should be avoided so far as possible. A certain amount of it, however, is unavoidable, if such food as that mentioned above is to reach the patients in a palatable condition.

Special Food Elevator Necessary

A special elevator or dumb waiter, preferably electric, and large enough to take the food cars, should be provided in the building, from the basement to each ward diet kitchen. The same elevator may be used for the removal of garbage



A gas-heated steam table, with a cast iron top, porcelain enameled. It has tight-fitting lap seams and each section is removable for easy cleaning. The top has two oblong meat platters, six cast iron soup or vegetable jars, and three gravy jars. The warming closet is galvanized with sliding doors and two shelves inside.

cans and for the delivery of the general supplies of the ward. It is very desirable that such provision be made, as neither the food nor garbage cans should be allowed in the passenger elevator. These special elevators also insure quicker delivery of the food, as the cars are not held up by the other activities of the hospital.

There are various kinds of food cars on the market, but the writer has never seen one that was satisfactory in every way. Many of them are made of wood or metal, without special means of keeping the food hot in transit, making it necessary to reheat it by some means, usually a steam table, after it is received. Objections to this, and the effect upon the taste of many kinds of food, are too obvious to need discussion. There are other cars in which an attempt is made to heat the car by means of hot water compartments, or in other ways, to which the objections are made that they either do not keep the food as hot as necessary, that they over cook it in transit, or dry it out. Electrically heated cars depend for their heat upon an electric unit which needs to be connected with the lighting circuit in order to generate the heat. Obviously there is no heat in such a car while it is being transferred from the kitchen to the ward diet kitchen, the time it is most needed, and at its best the heat from the electric unit is of little use. Also, none of these cars makes sufficient provision for the proper transportation of cold foods.

Fireless Cooker Food Cars Better

Food cars made on the principle of the fireless cooker are now on the market, and come nearer to solving the problem of the proper transportation of food than those above mentioned. The food can be placed in these in the general kitchen, and will remain hot for several hours. The cars are clean and easily cared for, and are found to be an improvement over the other methods. No steam table is needed in the serving room, the trays being set directly from the food car, without the necessity of reheating the food.

A better and more economical method of serving to patients is to serve the trays directly from the fireless cooker food car instead of setting the trays in the ward diet kitchen. In this method the trays are set with the empty dishes, and sometimes with such dishes as are to be served cold, and taken to the rooms or to the patients' bedsides. The car is then run from room to room or through the ward by an orderly or maid, accompanied by a nurse, and the dishes on the trays are filled with the hot food directly from the car. The food is thus served more quickly, as it is not handled so many times, and it is in a much better condition than it usually is after it has been reheated

in a steam table, and perhaps left standing while a large number of trays are being prepared and carried, one or two at a time, from the serving room to the patients. The method has the additional advantage of giving the patient some choice in the matter of his menu. This privilege is usually pleasing to the patient and is also eco-



A hospital diet kitchen steam table with overhead warming oven. The base is made of angle iron, black polished, the shelf and skirting are black polished iron and the frame is nickel plated. It has a copper meat pan, with nickel plated revolving top, four white china pots, with removable copper covers. The warming closet and sliding doors are of black polished iron with nickel plated trimmings.

nomical of food. The chief objection to such a system is that it is difficult to have hot dishes, as the trays containing the needed dishes must be distributed some time ahead of the arrival of the car. But as the dishes, though not hot, need not be particularly cold, the objection need not be a serious one and will be overbalanced by the advantages. With less work, and with great improvement in the service, and considerable saving of food, meals can be served in this way in about half the time it usually takes, when the trays are prepared in the ward diet kitchen. "Special" trays, that is, trays for patients on special diet, will be more safely prepared in the ward diet kitchen and taken to the patient from there, in order to avoid mistakes.

A convenient and practical division of the work of preparing and serving the food, between the various kitchens, is as follows: In the general kitchen, all food for nurses, interns, and employees, except pastry, desserts and salads. For the patients, all meats, except such steaks or chops as are ordered "special." All vegetables for those on general diet, cereals, and coffee.

In the pastry bakery, all pastry, rolls, desserts (including ice cream and ices), and salads.

In the special diet kitchen, special orders, those diets made from special food formulae, or in connection with which particular food problems are to be solved. All "between meal" beverages. Special feedings for infants, unless the pediatric service is large enough to justify a special room for the purpose.

In the ward diet kitchen, eggs, toast, small steaks and chops, tea and cocoa.

Dish Washing An Unsolved Problem

The washing of the dishes used by patients may be classed as one of the unsolved hospital problems. It is usually done in the ward diet kitchen, but the noise is very objectionable to the patients, and it is difficult not to make any noise. To meet this objection it has frequently been suggested that a central dish washing room be established and equipped with the necessary dish washing machine, and that all dishes from the various parts of the hospital be sent there after each meal, washed, and returned to the ward diet kitchens. Except in a very small hospital, caring for but one class of patients, the writer does not believe such a system either desirable or practical. While the noise on the wards will be reduced somewhat, it will not be entirely eliminated, as the dishes will need to be handled both in preparing them to be sent to the dish washing scullery, and in unloading them and putting them on the shelves when returned, and such saving of help as may result will be largely covered by the extra expense caused by the increased breakage resulting from the extra amount of handling of the dishes.

It will also be borne in mind that in most hospitals it is found desirable to provide different qualities of china for various classes of patients. Thus, private patients occupying expensive private rooms will expect more delicate china than that generally used for the free patients in the wards. If the dishes are all washed together in a common scullery, much confusion must inevitably result in connection with their return to their proper places. Special care in sterilization will also be needed with the dishes used by certain patients, and this is likely to be more safely done where they are handled in smaller quantities and with closer supervision.

For this reason, it seems best to equip each ward or division of the hospital with its own dishes, selected to suit the needs of the class of patients to be cared for there, and to have them washed in the ward diet kitchen of each department, as is the usual custom. Much can be done to eliminate or minimize the noise resulting from

the dish washing if care is taken, and if the ward diet kitchen is planned so that its doors do not open directly into a corridor adjacent to patients' rooms. The plan shown on page 408 is intended to illustrate how this can be done.

A common error in building hospitals is to plan too small a ward diet kitchen. The space should be ample to care for the equipment, to provide for the reception and unloading of the food car, and to enable four or five persons to work comfortably without congestion or confusion. For serving the food to twenty-five or thirty patients a minimum of three hundred and twenty square feet of floor space will be needed. The following equipment will be needed in a ward diet kitchen of this size:

- | | |
|--|---|
| 1 Refrigerator with separate compartment for milk, cream and butter. | 2 Dishwashing sinks (deep), or small dishwashing machine. |
| 1 Dish sterilizer. | 1 Cupboard for dishes and supplies. |
| 1 Clean dish counter. | 1 Dish warmer. |
| 1 Shallow sink. | 1 Tray rack, on wheels. |
| 1 Work table, steel, or steel top. | 1 Egg boiler, small, automatic. |
| 1 Toaster (electric). | 1 Double boiler (1 qt.). |
| 1 Hot plate, gas or electric. | 1 Steel fry pan (10 inches). |
| 1 Egg whip. | 1 Pepper shaker. |
| 1 1-qt. crock for salt. | 1 Butcher's knife. |
| 1 10-lb. can for sugar. | 1 Carving fork. |
| 1 Carving knife. | 1 Gravy ladle. |
| 1 Roast beef slicer. | 1 Can opener. |
| 1 Meat fork. | 1 Lemon squeezer. |
| 1 Garbage can (25 gals.). | 1 Water pitcher, enameled (4 qt.). |
| 2 Large spoons (12 in.). | 1 Rack for towels (paper or linen). |
| 1 Cork screw. | 1 Measuring cup. |
| 1 Heavy dishpan. | 2 Saucepans. |
| 2 Doz. dish towels. | 1 Rack for drying dish towels. |
| 1 Pail, enameled, 2 gals. | 1 Ice pick. |
| 1 Butter tub. | 30 Trays, aluminum or white enameled. |
| 1 Soiled dish counter. | |

The list of dishes, and glass and silverware needed will be given in another article in which such ware will be discussed.

GOVERNMENT UNDERTAKES BIG HOSPITAL PROGRAM

The bill providing \$18,600,000 for government hospitals was passed by Congress. The bill was the result of urgent requests from the Public Health Service and the American Legion, for adequate facilities for ex-service men. The immediate expenditure of \$6,100,000 for the improvement of hospitals now existing and \$12,500,000 for the construction of new hospitals was approved. The original plan of having five large hospitals throughout the country has been set aside, and the arrangements have been placed in the hands of the President and the Secretary of the Treasury to place the new hospitals as may be required. This is the largest hospital program ever undertaken by the government.

HOLD COURSE AT TUSKEGEE INSTITUTE, ALABAMA

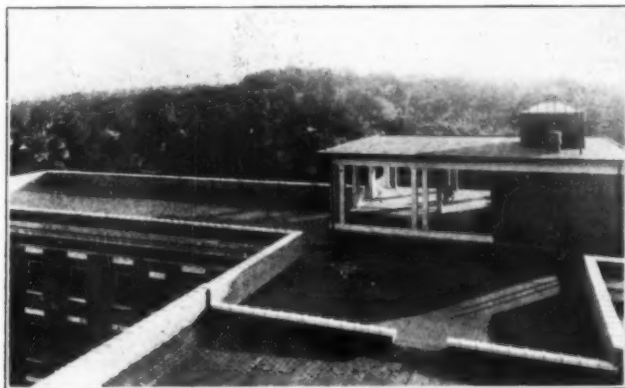
A postgraduate course in medicine and surgery is being given at the John A. Andrew Memorial Hospital, Tuskegee Institute, Alabama, beginning Monday, April 4, 1921, and continuing for four weeks. The course has received endorsements from any of the best men of the profession. The instructors will be leading men of both the white and colored races from different sections of the country. In consideration of the great difficulty in getting postgraduate work in the schools and hospitals, it would seem that this course should be well attended and prove a great success.

MAKING THE MOST OF THE HOSPITAL ROOF

BY CORNELIUS S. LODER, OF CORNELIUS S. LODER AND ASSOCIATES, HOSPITAL CONSULTANTS, NEW YORK

THE uses of the roofs in the Orient are worthy of serious consideration by hospital builders in the Occident. Using the roof for curative and recreative purposes will benefit the patient and increase hospital revenue. Each of these is of practical importance, for a larger revenue naturally results in better service to the patients.

Until recently, most hospitals considered their cellar space for furnace and storage purposes only. At the present time, through rearrangement, these basements are productive sections of hospitals. So the roofs, which are now regarded by many as merely shelters against the weather, should be put to productive, practical use.



The roof of the Waterbury Hospital, Waterbury, Conn., quite fully illustrates the possibilities of hospital roof service. Here is a large area entirely unused except for slight recreational purposes. The elevator and lavatories are to be found in the enclosed space, and there is a covered space for protection from storms. The larger roof could just as well be used for the enjoyment of the patients, and as a productive part of the hospital.

To some, this idea of putting the roof to some use may seem radical. Many conservative hospital executives are rather averse to introducing unprecedented and unorthodox methods. In such hospitals the authorities later find that their field of service has been seriously limited by this lack of foresight. The progressive institutional executives, as well as the modern hospital architects, who are seeking the best plans for their clients, will give this matter earnest consideration. Some may think it will be very expensive. But after the initial expense, the cost of maintenance will not prove a burden, as special appliances will be prepared to prolong the life of the roofing equipment, and the cost of operating may be less than that of the ordinary patients' floor. This is true because there are no side walls and ceilings. The daylight saves the cost of artificial lighting, the absence of windows lessens the task of cleaning, while the care of the roof

necessitates only cleaning of a general character.

There are many purposes for which the roof could be used almost continuously. Patients may be assigned to the roof just as to a private room or ward, space being allotted to them and fees charged for all the privileges. Nurses and attendants would be assigned for day and night roof duty. Beds should be placed on a properly prepared roof for assignment to those patients whose recovery can be hastened by supervised fresh air treatment. Tuberculosis, pneumonia, influenza, respiratory and cardiac disorders, anemias, acute infections, all cases of orthopedic treatment, feeding cases, indeed there are few cases in which there are not indisputable arguments in favor of this treatment. These statements have been fully confirmed through messages received from the most eminent hospital managers in the United States. Dr. A. R. Hatcher, of Kansas, for example, says, "There is no limit to the variety of cases that are benefited by fresh air." In our correspondence with Dr. C. H. Mayo, he says: "We are now building a hospital in which arrangements are being made for roof open air treatment, and there are also two other hospitals here which are using it to some extent." Dr. Mayo further strongly advocates open air treatment for patients, and calls



This photograph from the Mercy Hospital, Pittsburgh, Pa., shows a development for roof garden purposes, with the recreational facilities as the main object. The elevator, dumb waiter and lavatories are probably in the small covered space. Additional space could easily have been added as a place where patients could be placed for treatment and examination.

attention to this service as it has developed on the continent of Europe and is being applied in Colorado.

The growing demand for outdoor treatment



This photograph from the hospital of the Ruptured and Crippled Children of New York City, shows a roof actually in service, and happily meeting the requirements of the institution. The superintendent expresses himself as more than pleased with the results.

must be met. Only in a few places are the climatic conditions unfavorable to outdoor treatment, and even there for only a portion of the year; as, for example, Texas, where the country is visited with sand storms; some of our southern states, where there is intense heat; and the northern Erie states and Canada, where there is severe winter cold. These conditions are only temporary, however.

On the roof, patients are protected from outside noises, they are not annoyed with slamming doors, with loud talking, with tramping of feet, and many other irritating experiences are lessened, thus bringing comfort and countless benefits from this outdoor treatment. In cities the roof offers the patient the opportunity of receiving fresh air treatment away from the noise and dirt of the street, in rural districts the use of the roof is preferable to the use of the hospital grounds because of its protection from storms, and because it keeps the patients more within the protection and control of the hospital. For this reason, many nurses will prefer roof assignment.

If a hospital is so unfortunately located as to be in the path of unwholesome soft coal smoke clouds from factories or railroads, possibly its

first duty to itself as an institution, as well as to the patronage which it craves, is to seek relocation. Another step might be an intelligently devised and executed plan of publicity to arouse public opinion to demand the abatement of this smoke nuisance, as there are, of course, appliances which consume smoke.

In some portions of the country objections might be raised because of flies, mosquitoes, or other insects which may prove troublesome to the patients at certain seasons of the year. Protection may easily be effected through the use of bed screens or of netting covering the entire roof.

Cripples will find in the roof garden a comfortable and serviceable lounging room, convalescents will satisfy their desire for being out of doors, and children will derive pleasure and delight in the open air play space. A part of the roof may be assigned to the occupational department, commendably combining work and pleasure.

When the roof is not being occupied by patients it may be used for various hospital functions. Meetings of women's auxiliaries and hospital committees may be made less formal and more enjoyable by being held there; or it may be con-

verted into an attractive study or recreation place for nurses.

As an ordinary roof is built merely as a protection against the weather, it can be easily seen that for this other service the entire structure must be stronger. A type of construction will be necessary which will withstand traffic of wheel chairs, of movable beds, of the walking of patients and attendants, of the romping of playful children. The sheet metal roofing, sometimes used, needs wooden runways, which deteriorate rapidly and do not give complete satisfaction because they are hard to walk upon, and hold dirt and moisture. Difficulties are involved in the use of gravel. Most architects seem to prefer strong quarry tile, set in pitch or other mastic composition, upon a heavy felt roof. In these matters heat and reflection also must be considered.

An interesting feature is that outside of the stronger framing construction which might be needed, the cost of these roofs will not be an appreciable item of increase over that which the permanent hospital building requires. Experience shows that metal roofs not only have a larger initial cost but that the maintenance, repairs, and replacements make these roofings undesirable.

The tile roof is sometimes recommended. The cost of this will be about three to four times that of the properly built concrete roof on the mastic



The third floor outdoor ward of Peter Bent Brigham Hospital, Boston.

foundation. The latter seems in every way a desirable one for all hospitals, most readily meeting the requirements of hospital roof service, especially as there are processes for waterproofing concrete structure.

These uses of the roof will necessitate specially prepared equipment and furnishings to meet its peculiar demands; such as elevator, dumbwaiter, laundry chute, patient's call system, lighting service, diet kitchen, lavatories, and a closed space for protection against storm, with an office for the roof nurse. Other equipment especially adapted to outdoor uses will be necessary, such as heavy blankets for the protection from the cold, rubber coverings to ward off storms, sun umbrellas as a shade from heat and light, field glasses and a small telescope, with other desirable appliances for the comfort and pleasure of the patients. The installation of proper equipment for the roof makes possible its use in all kinds of weather, if this factor in the particular section of the country in which the hospital is located is studied.

This practical use of hospital roofs offers to manufacturers an opportunity for expanding their business by constructing and offering to the hospitals specific supplies prepared and adapted to this purpose. Manufacturers should make a study of this problem and



This shows how Peter Bent Brigham Hospital of Boston uses open air treatment on this second floor terrace.

produce a serviceable output for such use. Architects and builders should give particular attention to this matter because it is reasonable to expect that before long every up-to-date hospital will put the roof to a practical use. It is advisable that they have available definite plans on hospital roof construction to submit to building committees.

A study of this situation will show numerous

arguments in favor of this adaptation of hospital roofs, and every objection will be overcome. From every angle the roof offers to the hospital authorities a marked opportunity for a happy combination of care for its patients, of recreation and rest from fatigue for nurses and for attendants, and of increased revenue for the institution.

BUILDING ORDINANCES IN RELATION TO HOSPITAL CONSTRUCTION

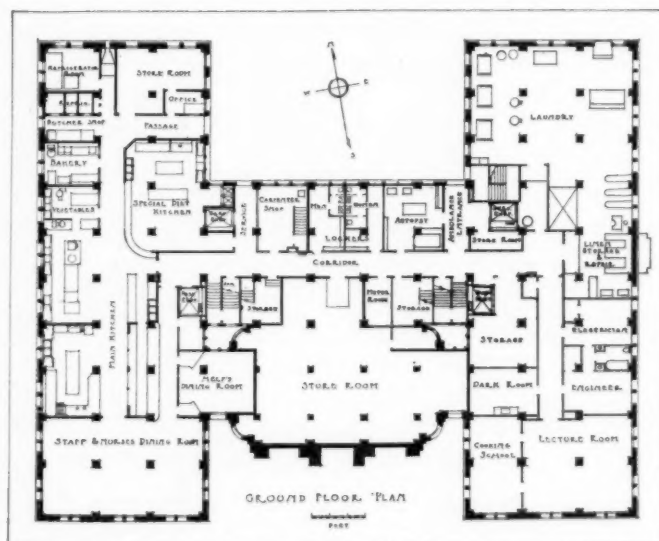
BY DAVID HADDEN, M.D., OAKLAND, CAL.

TO ANYONE occupied in the planning and construction of a modern hospital building, the building ordinances of the community offer a most interesting and perplexing study. It appears that the average building ordinance of the western part of the United States is copied from that of Chicago or some large city of the East. As a rule, roof warmers and other gross requirements based on weather variations are omitted, but the minor features that weather conditions should modify are overlooked. In fact the requirements for hospital construction show, as a rule, an absolute lack of knowledge of hospital construction growth.

A city usually begins by restricting the districts in which a hospital may be built. The more populous a district is, especially where such population is crowded into apartments and hotels, the inhabitants of which are those most in need of hospital accommodations, the more likely is such a district to be placed outside the hospital zones. It is evident that to the average individual a hospital conveys the idea of the old almshouse where the infirm and indigent are always in evidence. In fact, the rather questionable tendency of some more modern institutions to have the occupants in view on lawns or porches seems to be to develop the tendency of considering a hospital a detriment to the neighborhood. There is no more reason why a hospital, which as a modern

development, is a hotel for the sick, should in any great degree detract from the value of that district as a residence area, any more than a modern hotel. But so general is the impression of the hospital as a detriment that not only is the district restricted but the building is required to be placed at a considerable distance from the property lines.

One of our very large and very thickly settled cities requires a hospital building to be placed not less than one hundred feet from its property lines unless the adjoining property is a business block wholly. This city also requires that no "infectious or contagious" diseases shall be cared for in any hospital within its bounds. It also permits any property owner within one hundred feet of any hospital already established to put the hospital out of business; and, as the matter stands at present, each hospital in the town is being



Ground floor plan of the general hospital building of the Oakland Hospital Corporation.

conducted as a nuisance, and subject to a fine for each day so conducted. These same cities permit undertaking establishments in selected business or semi-business districts and in many cases in residence areas, without any limitation as to property lines. Yet any attempt to construct a hospital in these districts brings a storm of protest.

The city of Oakland, Cal., has a building ordinance framed and adopted in 1918. In many respects it is a good ordinance, not only from the

First floor plan of the general hospital building of the Oakland Hospital Corporation.

feeding the occupants of these rooms, and the fact that the hospital may be strictly a surgical or maternity unit is conveniently overlooked. Of course its drafters may say that we must be prepared to care for cases developing in our institution, but such foresight should also have devised a system of catering to these unfortunate ones.

The window space and ventilating requirements are of interest. Our windows must be "15 per cent of the floor area, and one-half of such window shall be openable." It is also required that "the top sash shall be as near the ceiling as practicable, and the top sash shall be hinged at the bottom to swing in for ventilation and shall have guards at the sides of such hinged sash, so as to form a hopper deflecting the air to the ceiling." How would such a provision strike the man who is an advocate and designer of the hundred per cent opening, or the ventilating engineer who advocates closed windows for efficient suction? We are required, also, to put "mechanical exhaust ventilation in all toilets, kitchens, pantries, and utility rooms."

What will the ordinance framers say of the hospital superintendent who said "transoms are not needed for ventilation if the windows are properly located. In many cases they are seldom or never used; they represent an investment expense; they collect dust and dirt and require labor for cleaning; and they are a useless appendage of a modern building."

The matter of window screening has received absolutely no consideration in this modern ordinance, probably because we must provide a "ref-use destroyer," and a "glazed clothes chute."

As the new building of the Oakland Hospital Corporation will be the first hospital to be built under this ordinance of 1918, it is fortunate that Oakland has at the present time a government whose individuals are eager to have the city develop along the most modern lines, so that undoubtedly provisions of the ordinance which conflict with the latest ideas in hospital construction will be modified. The council recently rejected an ordinance offered for passage which would prevent the establishment of a hospital within

two hundred feet of a public park. The framers of the bill gave as their reasons that a "hospital was a detriment to the public health and safety." Still more recently another bill, that required a distance of seventy-five feet between the building and the property lines, was rejected. These rejections leave as law our present requirement of twenty feet as demanded in the ordinance of 1918.

The building under development for the Oakland Hospital Corporation has been planned with the idea of providing a modern hotel service for the sick. It has been our desire to create the impression of a hotel rather than a hospital, and for this purpose the main floor is developed along the lines of a hotel lobby. The flower stand, drug store, and notion counters will emphasize this hotel aspect, and a new venture in the shape of an optical department, it is hoped, will encourage our oculists to separate themselves from the prescribing optician.

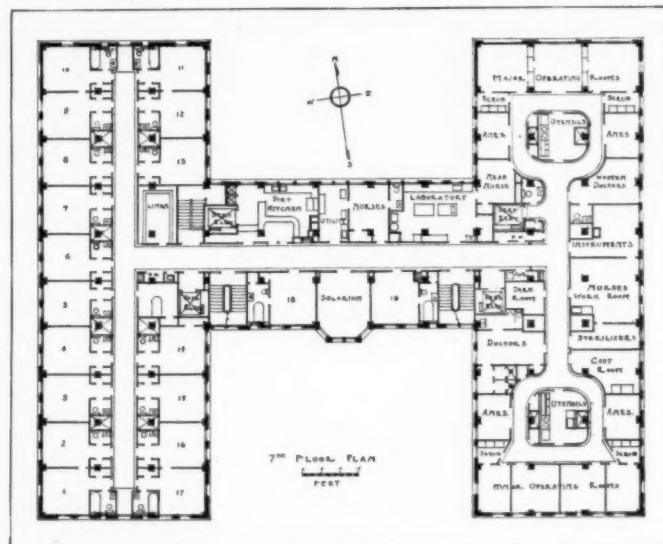
In the equipment of our operating room service we hope, by giving them the conditions suitable, to encourage operating dentists to do their major dentistry under the safety of proper anesthesia and asepsis.

The ideal striven for in developing our plans is the saving of time and strength for the physician, nurse, and patient, with the greatest comfort for the patient. We have eliminated all wards,

for we feel sure that the private room is the only way to procure for the patient the ideal conditions for return to health. Is it reasonable to suppose that a patient who in his own home is used to, and demands privacy, will do better when subjected to the unpleasant features of a ward? Unless the patients are under staff care, the opportunity offered to discuss and compare physicians is great, usually to the detriment of one or more of the profession.

Though our plans are practically completed, we will still value whatever criticisms will aid us to greater efficiency and service.

The Hospital Library and Service Bureau of the American Hospital Association announces that it will have a special exhibit of floor plans, clinical records and interesting material at the Catholic Hospital Association, to be held at St. Paul, Minn., June 21-24, inclusive.



Seventh floor plan of the general hospital building of the Oakland Hospital Corporation.

FACTS YOU SHOULD KNOW ABOUT ABSORBENT GAUZE AND COTTON*

IT IS a curious fact that in these days when the hospital executive knows just about all there is to know concerning his equipment, and tries to have a personnel which is up to the minute in efficiency, little is known about the absorbent gauze and cotton which is used so continu-

pared, but as far as actually proving the worth of one over the other, do you do it?

For instance, do you test this point before buying? An important index of the thoroughness of the bleaching of cotton, on which the absorbency as well as the whiteness depends, is the ash or



This is the first stage in the cotton process, in the southern field. The pickers remove the inner contents of the boll, and the cotton is then transported to the gin where the fibers are pulled from the seed.

ously, and upon which so much depends. Up to this time small attention has been given to this subject, and this article is written with the hope of throwing some light on it and helping the ordinary hospital executive to recognize just what kind of products will best serve his needs.

It is rather astonishing that few if any buyers for hospitals put the gauze or cotton which they purchase to any actual test. The salesman calls and usually gives his regular line of "dope"; and what more natural than that he should think his particular brand of products the best on the market? If the salesman does not call, perhaps the supplies are obtained through some local store, or a jobber. Samples may be considered, and even com-

residue of mineral matter which remains after the organic matter has been removed by burning. Good raw cotton has an ash of from .9 to 1.2 per cent, and good bleached cotton should not have more than .1 or 1 per cent.

Price is a great factor in the buying of hospital supplies. Where appropriations are limited, and commodities continue to rise in price, it is a very necessary factor. The difference of a quarter of a cent per yard or pound certainly counts up on a product where such large amounts are used. However, all things, considered, price and quality should go hand in hand.

Since the weight of the yarn is a factor of importance, because it shows just how much actual fiber goes into a pound, the following table is given, showing the amounts to the pound for meshes which are more or less familiar.

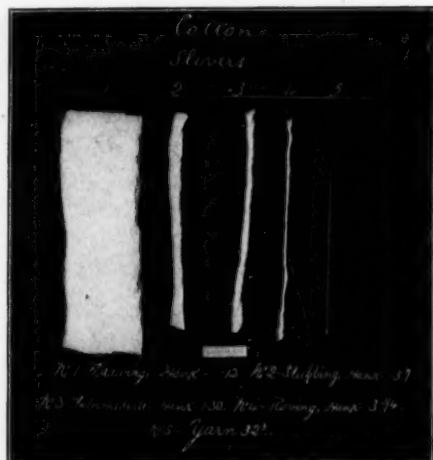


This section of the carding room of the Red Cross Cotton Mills gives a good idea of how the cotton ropes look as they come from the machines.

*For assistance in the presentation of this article acknowledgment is made to the Lewis Manufacturing Company, Johnson and Johnson, The Hygienic Fiber Company, Hampton Mills, and the Kinston Cotton Mills.

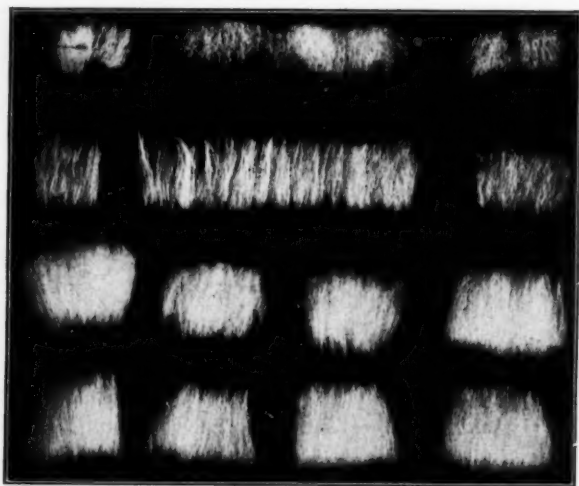
	Bleached gauze	Unbleached gauze
Count...22 by 12	25 yds. to a lb.	23 yds. to a lb.
Count...20 by 16	23 yds. to a lb.	21 yds. to a lb.
Count...44 by 40	9½ yds. to a lb.	8 yds. to a lb.
Count...60 by 48	10½ yds. to a lb.	9½ yds. to a lb.

("Count" is the technical term for the mesh of gauze—giving the number of threads to the square inch. Thus in the coarsest grade given, 20 by 12, there are twenty threads in the warp, and twelve in the woof.)



Illustrating the progress of loose cotton fiber towards the thread in weaving gauze. At the left the cotton is shown as it comes from the carding and combing process, a loosely finished rope or "sliver." By repeated stretching and twisting this "sliver" is reduced to a thread, as shown at the right.

To give some idea of the difference in counts, the twenty-two by twelve is the coarse mesh so often used for dressings, and the forty-four by forty the fine mesh so often used for bandages, the compare the difference in weight. There is



This is cotton fiber as the expert examiner sees it. The two upper rows represent cotton rejected on account of length and character of staple. Certain necessary qualities in cotton fiber are: length of fiber, smallness or fineness in diameter, evenness, elasticity, strength, color, hollowness or tube-like construction, natural twist, and corrugated edges.

also a difference in the number of yards to a pound in the bleached and unbleached gauze, the bleached has been treated to a process which removes the wax, fats, color, woody material, and mineral

matter from the fiber, and makes it soft in texture—hence a pound of this latter has more yardage. Isn't it a simple thing to know, but a fact which few of us take into account in buying supplies?

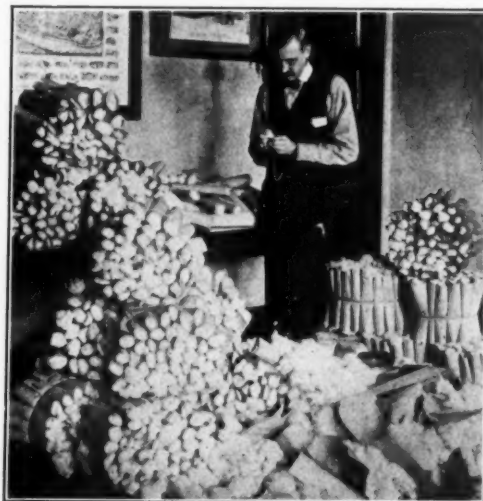
An analysis of raw cotton shows that it is made up of approximately:

Water	7.00 per cent
Ash	1.20 per cent
Fat and wax	5.00 per cent
Coloring matter50 per cent
Woody matter75 per cent
Cellulose	86.55 per cent

By bleaching, this is reduced approximately to:

Cellulose	92.90 per cent
Ash10 per cent
Water	7.00 per cent

Have you ever been through a cotton mill and actually seen the various processes to which cotton is subjected in order to produce absorbent gauze? Have you ever watched the cotton being changed from a dirty, linty substance to a clean



The cotton is examined by an expert hunting for defects among the fibers.

white cloth? Have you ever seen anything more on the production of cotton than a picture of Eli Whitney and his first cotton gin?

Let us begin with the product in the field, and make a hasty but enlightening review of the production of cotton and gauze.

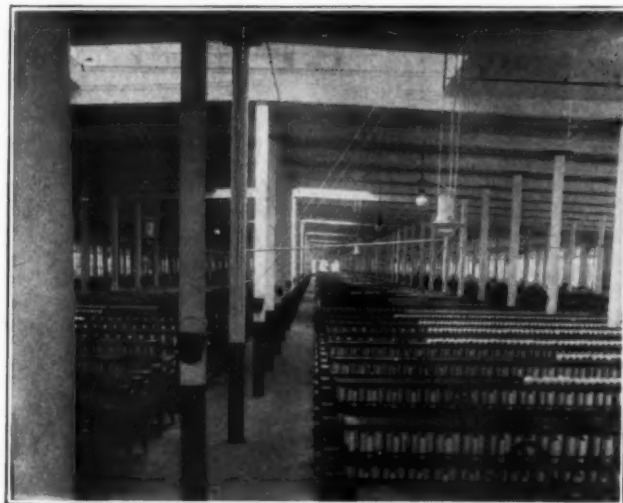
Cotton is raised in the field in much the same manner as is corn. The seeds are planted in rows, and as soon as the plants have reached a moderate height the weaklings are pulled up by the roots in order that the remaining plants may get all the sustenance from the soil. There is no set time for gathering a cotton crop. Each field is gone over frequently and those of the bolls that have ripened are plucked from their stalks whenever found. This goes on from two months after the time of planting until frost. When fully dried, the bolls are gathered up and hauled away. They

are then ready for the first of the numerous operations that are necessary in order that they may be converted into cotton and surgical gauze.

Specifically, the task is to separate the fibers from the seed. Actually, the boll is picked to pieces, the mass of cotton being rent to shreds by a big, powerful machine—the cotton gin.

The ginned fiber must be examined on its arrival at the factory in order that its length, color, fineness, etc., and the cleanness of ginning may be determined. Several bales are opened at one time, the contents of the first bale being spread out evenly on the floor of a large room, and each of the others added in turn, in layers. By this process each lot mixes with all of the other lots or bales, thereby producing a mass that is more or less uniform throughout.

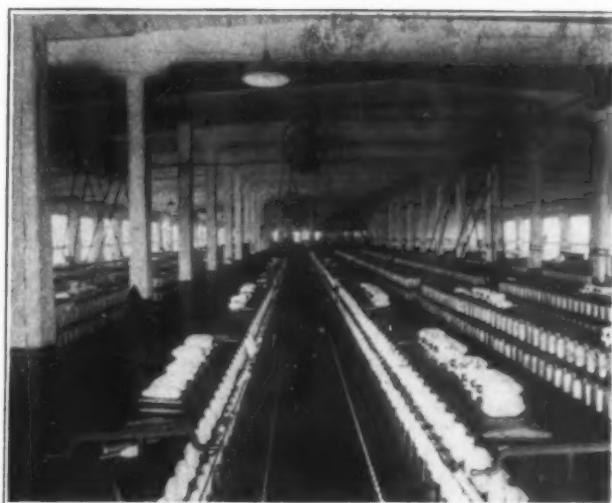
The cotton is now ready to put through the first of the various machines which are required



There are four different classes of machines through which the thread must pass in the spinning of yarn for gauze. In every stage the twisting is also going on. In this manner a rough rope an inch in diameter is transformed into a tightly spun fine thread.

to clean it and straighten out the fibers. At this stage of the manufacturing process there are many knots and tangles caused by the pulling of teeth of the gin, and often bits of pods, leaves, and other foreign matter, all of which need attention. Depending upon the fineness of the yarn to be produced, two, three, or even four machines of the "picker" type are used. This is an elaborate process, by which the fibers are made cleaner, and more closely knit together. The resulting lap is now ready for carding, which is really the first step in the process of putting the fibers parallel and making them lie straight so that when the twisting begins it can be smoothly carried on without interruption by the forming of lumps, knots, etc.

The end of the lap is carried forward until it enters a large cylinder, the face of which is vir-



Spinning yarn for gauze is the reducing by gradual stages of the sliver or rope of fiber, turned out by the carding machines. This reduction is accomplished by stretching out, or attenuating, while at the same time the rope is made finer and stronger by twisting.

tually a fine steel brush. This draws forward some of the fibers while others are held back by a pressure roller revolving at a slower speed than the cylinder.

When the carding is done properly and thoroughly, all of the fibers are ready for spinning. Since different length fibers can be used for different machines, in order that the material may enter the machine, it is necessary that it be "twisted" so that it be strong enough to hold together. By passing it through a "slubber" the twist is accomplished. Succeeding processes stretch the slubber from half a hank to twelve hanks. The spinning machine, like all of the others, is complicated and ingenious. It takes the product from a frame, draws it out into longer and finer strands and twists it into a compact yarn.

When the housewife uses her sewing machine, she has to thread it first. So, also, in weaving,



Weaving gauze is an interlacing of threads, generally at right angles, to form a texture or cloth.



This is the way the seed looks with the fiber attached, before the ginning process has begun.

the loom must be threaded with the warp. For plain weaving there are two sets of needles—one harness goes up as the other goes down, so that the woof will pass over and under each thread, alternately. Since threading the machine is rather a complicated process, the ends of the old warp are knotted to the new one by a small machine which can tie four knots per second.

Now the cotton is in cloth form, but, before it is usable as hospital gauze, there is another series of operations to which it must be subjected.

It must be remembered that as yet the product has not been bleached—it is a dirty yellow, or buff color, called "gray goods." Bleaching is done in two steps, the first of which is the "kier boil." The kier is a large covered kettle. In it from one to five tons, or 50,000 to 200,000 yards of gauze are placed. Water and cleansing agents are added and all are then boiled for a long time under pressure.

The goods are next given several thorough washings, after which the color in the cloth is destroyed by oxidation with chlorine. After more washings, then neutralization of any remaining alkali or chlorine, and three or four washings, the cotton and gauze is white and absorbent. At this point (leaving the water out of consideration) high grade gauze is more than 99.9 per cent pure cellulose. From this point on, nothing is added to high grade gauze and every precaution is taken to insure its purity and cleanliness.

When the gauze is taken from the kiers, it is piled into containers which are wheeled away to designated places before a machine which will dry it, stretch it into uniform width, and roll it upon "tenter rolls"—all in one operation.

The tenter rolls, which look rather like large

spools, serve as a base from which the smaller amounts of the now finished gauze can be unwound. The one hundred yard bolt, package goods, bandages and bandage rolls, and all other gauze supplies are now made directly from the large piece, and as they come from the operator's hands they are neatly packed into a bin which is wheeled to the wrapping room and there given final form. The wrapped product is now ready for the store or packing room.

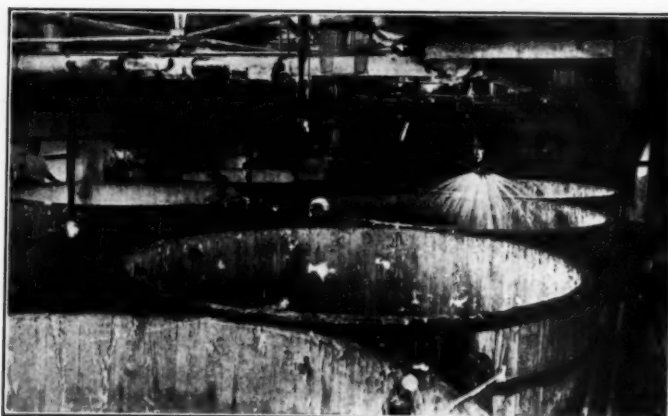
Although the cotton used for the weaving of gauze is subjected to more or less the same sort of operations, there is enough difference for cotton, as such, to merit some description here of the final processes by which this becomes the soft, attractive rolls which we know.

In the case of the cotton after kier boiling and bleaching, it is washed as gauze, and most of the water is then thrown out in a centrifugal dryer. Next the matted cotton is pulled apart and lightened in a "breaker," and then dried by pressing slowly on a moving apron through a hot air chamber.

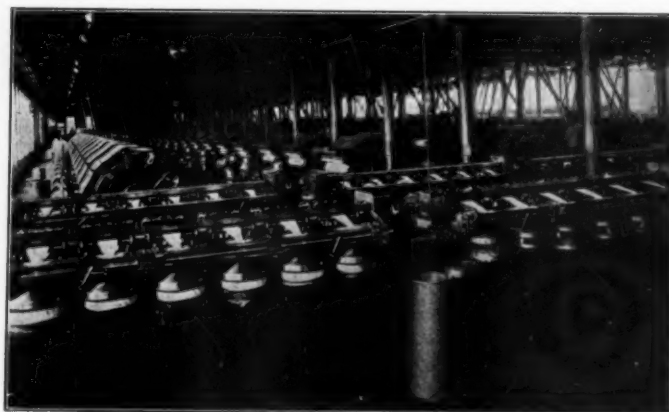
The cotton is then passed through two more "pickers" or "breakers," which loosen the fiber and deliver it in a "lap" or thickly wadded web in which the fibers run in every direction.

Waste cotton is marketed in this form. The finer grades are "carded," giving them uniformity and fluffiness usually associated with absorbent cotton.

The beating and cleansing of cotton for the manufacture of surgical gauze is very much like that for the production of absorbent cotton, the main difference being that when the sheet emerges from the carding machine if it is intended for gauze, it is coiled into a loose rope called a "sliver." The picture shows a section of the carding room at the Chicopee Mills, Chicopee Falls, Mass.



A hydrolytic laboratory, where cotton and gauze are made absorbent. The gauze after being woven, is sewn into an endless rope that is carried automatically to the hydrolytic laboratory, where, passing over rollers, it is transferred from solution to solution which extract the oils and waxes and leave it absorbent. After the final washing it is carried automatically to a drier without having been touched by human hands.



The beating and cleansing of cotton for the manufacture of surgical gauze is very much like that for the production of absorbent cotton, the main difference being that when the sheet emerges from the carding machine if it is intended for gauze, it is coiled into a loose rope called a "sliver." The picture shows a section of the carding room at the Chicopee Mills, Chicopee Falls, Mass.

The carding machine is made of different combined sizes of wire teeth. The cotton, passing over these, is combed and re-combed. The layers of carded material are gathered in a runway and pressed together into a header roll. This is the basic unit from which the rolls we are familiar with are produced.

In all mills where high grade products are sold there is a rigid standard of inspection. The inspectors are always actively "on the job," and they must answer for six necessary qualities—color, weave, absorbency, dimensions, cleanliness and weight. The regulation inspection is thorough, and material is rated "first class," "seconds," and "thirds," according to its merits.

It is a logical step to proceed from the fabrication of the gauze to the ways by which good gauze may be distinguished from inferior. In order to know what sorts of gauze and cotton will be best for use in your institution, you must realize, first of all, that many of the gauzes on the market today vary widely in certain fundamental ways. The sort of service which you will get from the gauze and cotton you use will depend directly on how well adapted they are to meet your particular needs.

When it has been shown repeatedly that there are wide variations in these products, can you be sure which sort will prove the safest and most efficient for your hospital until you have made a careful and intelligent comparison of the different qualities and character-



The card room at the Kinston Cotton Mills, Kinston, N. C. Raw cotton on its way to become absorbent, is carded by passing through machines consisting of cylinders covered with teeth which act as combs, laying the individual fibers out straight and parallel.

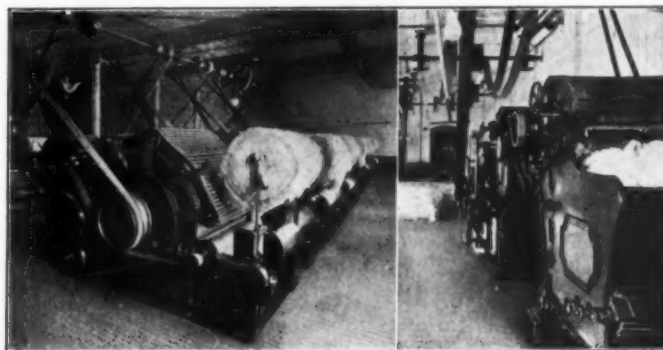
istics in each? One of the first essentials for absorbent gauze and cotton which is to be used in hospitals is that it have quick and active absorbency. Leading surgeons agree that this is of prime importance in surgical work.

There is an interesting test which shows the big absorbency variance in gauze. If you will try it, it will show you some significant facts. Take quarter yard lengths of as many different brands of gauze as you can assemble for inspection. Fold one of the

quarter yard lengths into a four inch square, press it lightly between the palms, and drop it in a pan of water. Note by your watch the exact number of seconds it takes this to sink. Remove, then drop in the water a second piece similarly prepared from another sample and note the time it takes that to become completely submerged.

Repeat with as many samples as you have. You will discover a fact to which possibly you have not given much attention before. There is quite a difference in the time necessary for submergence in the case of the different brands, ranging from almost instantaneous absorption in the case of the best grades, to little or no absorption in the poorest grades. You can apply this submergence test, also, to the various brands of absorbent cotton, using about one gram rolled into a compact ball.

Cotton, as it grows, a small handful of fibers, closely matted together and encasing the seeds



The machines at the right open up the mass of cotton fibers, pick it apart, blowing away the leaves and impurities. The machines at the left gather the fibers together again, form a blanket or sheet of the fibers and wind the blanket into rolls.

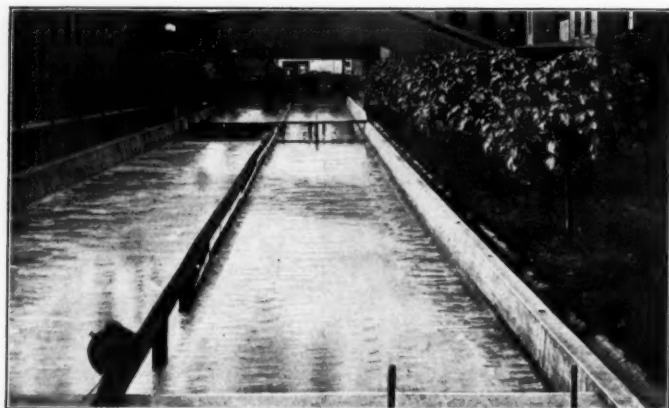


Weaving gauze in one of the weaving rooms at the Red Cross Cotton Mills. This method is slightly different from the old hand process when the weaver had to lift up every thread of the lengthwise set, and pass it under a shuttle containing the transverse thread.

of the plant, is naturally non-absorbent. In order to make it absorbent, it is necessary that all the oil be removed. It must be carefully prepared and bleached to remove all encrusting impurities and to free it from waxes, greasy matters, etc., which serve as water-repellent materials. If great care is not taken to control these processes of cleansing and bleaching, a weakening of the fiber may result. The necessary mechanical and chemical manipulations can be carried out in such a way, however, that tensile strength is not impaired.

An easy test for tensile strength is simple washing. Gauze which stands up well under re-washing is the gauze which is economical to buy. It will always hold and do the work which is required.

The second characteristic that gauze, which is to meet most satisfactorily the tests of service, must possess, is softness of finish. All buy-



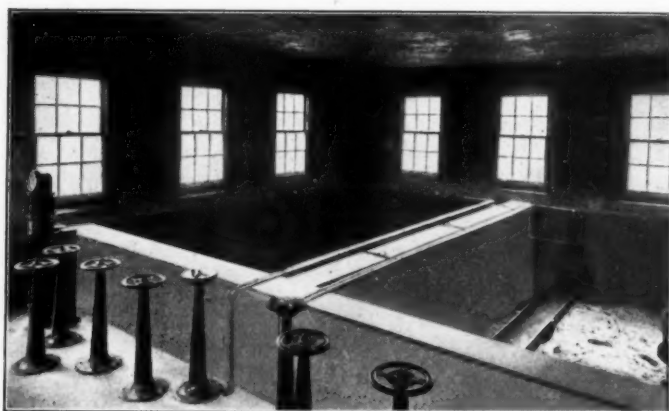
Water settling of sedimentation basin. Raw, or impure water, as it flows into this basin, becomes mixed with the coagulents, a gelatinous flocculent precipitant, which settles out carrying with it particles of dirt, etc. The process requires several hours.

ers will agree that this is an important point to consider, as there must be no roughness or stiffness. Especially for delicate work, a gauze which is entirely free from troublesome knots, loose threads, and cotton dust is the one to be chosen.

The difference in the texture of different gauzes can be noted at once simply by feeling of them, carefully, with the hand. Not all have the same uniformity of weave, and smoothness of finish. These are important things to look for. Hospital buyers and superintendents should be sure that the gauze they buy measures up as high as possible in these tests.

In the third place, the gauze which is ideal for hospital use should have a pure white bleach obtained without the use of an excess of chemicals, and should be delivered to the consumer in a spotless, unwrinkled condition.

Such gauze cannot be delivered, unless it has



Part of the water filter basin. The water, after precipitation with the coagulant, flows on to the filter bed, thence through layers of sand three or four feet deep. Each sand grain assists in collecting the dirt and bacteria.

been manufactured in mills where sunlight and air are admitted freely. Furthermore, it must be wrapped in covers that will exclude all dust and foreign substances, which would be very injurious if they were brought in contact with wounds.

It is necessary, too, that the gauze be folded straight and that it be kept unwrinkled. If this is not true, much time may be wasted in putting it in shape so that it can be used to best advantage after it reaches the hospital.

As with gauze, in the matter of absorbent cotton there are certain characteristics which must be demanded if maximum service is to be realized. In addition to the all important maximum absorbency and capillarity noted above, whiteness, cleanness, length of fiber, weight, and convenient put-up are important. In general, the longer the cotton fiber, the more desirable the cotton, for it holds together better, is finer and softer.

At the beginning of this article some mention



A corner of a bacteriological laboratory. Sterilization processes are controlled from here and check tests made of finished products.

was made about the various "counts" of gauze. Is it generally known that there are more than a dozen meshes in common use at the present time? If there are so many, then there must be some reason for such a variety, and some way of dis-



Try this absorbency test on the cotton you are using. Roll a small ball tightly between thumb and forefinger, drop it into a glass of water, and note by the second hand on your watch, how long before it sinks. There is a surprising difference in the time necessary for different brands, ranging from instantaneous submergence in the best grades, to little or no absorption in the poorest grades.

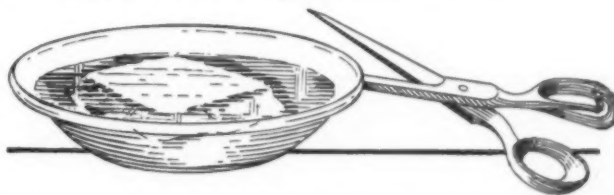
cerning between the different ones. Moreover, if there is such a wide variety from which to choose, wouldn't it be possible to buy different grades, and have the most suitable for each different type of work in the institution?

The coarsest meshes, twenty by twelve and twenty by sixteen, are ordinarily bought for making pads, wicks, and dressings of different kinds. Where laundry costs are low, a very considerable saving in gauze bills may be effected by purchasing a heavier count, such as twenty-two by eighteen or twenty-four by twenty. Aside from the fact that these make better dressings, they may be washed and re-washed, and still do their work effectively. Although the initial outlay is greater, the final cost is low, since considerable yardage is saved.

Finer counts are used for making bandages. Forty-four by forty is accepted as a standard

grade for this purpose, but others, such as twenty-eight by twenty-four, thirty-two by twenty-eight, and thirty-six by thirty-two, are in daily use. Because in these the threads are more closely woven, the heavier meshes will give bandages with good tensile strength.

As with gauze, so with cotton, for different purposes, different grades should be used. For delicate work, on the eye, ear, nose, etc., the high grade, long fibered cottons are preferred. This grade, of course, is expensive at the present time, but it is highly absorbent, very clean and pure, and most effective. For ordinary institutional use a medium grade of cotton is required; in heavy drainage cases or cases where large amounts of liquid must be taken up, waste cotton can be used economically. A simple way of telling the difference between grades of cotton is through practically superficial observation.



To test your cotton for soluble coloring matter and impurities, cut a layer, six inches square, carefully place it on the surface of water in a basin. It will sink and the water will rise through the mass of cotton. There should be no coloration or dirt at the moment that the cotton is submerged.

The better cottons are thoroughly bleached, show no specks or lumps, and have a soft and even smoothness of texture. By merely pulling the material apart, one can tell something of the fiber—waste will have little or no "stretching" power, while a high grade material will not pull apart easily; it will tend to cling, for the fibers are longer.

And what are the most important things to



Steam vacuum sterilizers. The sterilization is carried on in a special room, with tile floor and walls, which forms a connecting link between the factories and the packing departments. All goods pass outward through this battery of sterilizers. The capacity of each sterilizer is 12,000 bandages at each operation.

remember when buying gauze and cotton? That they have a pure white bleach, maximum absorbency, and guaranteed cleanliness, with, in the case of gauze, a soft texture and undiminished textile strength. At first these seem to make a rather long list, but in reality these important characteristics are simple. A little practice in watching for new gauze as it comes in, testing it, and the buyer is soon familiar with all these requirements.

Moreover, it is surprising what real satisfac-

tion is to be gained through having an accurate knowledge of the quality of what one is buying, just as you know whether or not the suit which you wear is worth the money you paid for it, and if it is giving you the service which can be expected of it, so with your hospital supplies. "It's the little things which count"—though seemingly minor quantities, they are extremely important. See to it that you are one of those who can distinguish.

THE NEW BUILDING OF THE STANFORD SCHOOL OF NURSING

BY GEORGE B. SOMERS, M.D., PHYSICIAN SUPERINTENDENT, STANFORD SCHOOL OF NURSING, UNIVERSITY HOSPITALS, SAN FRANCISCO, CAL.

LANE and Stanford University hospitals belong to the medical department of Stanford University. The two buildings are side by side, connecting, and under one management. Lane Hospital is used for teaching purposes and the accommodation of clinic patients, while Stanford University Hospital is used for the care of private patients only. The latter building is new and beautifully equipped. It is provided with solariums, sleeping balconies, Zander rooms, hydrotherapeutic, electrotherapeutic, and x-ray departments. The capacity of the two hospitals is three hundred beds.

The nurses of the training school in connection with these hospitals have been, up to this time, accommodated in eleven private residences situated in the neighborhood. Nine of these residences were situated immediately opposite the hospitals on a block of land which which was purchased by the university trustees for building purposes. The center of this block, consisting of a fifty vara lot ($137\frac{1}{2}$ by $137\frac{1}{2}$ feet), will be almost completely covered by the new building. On the adjacent corners the plans of the board of trustees call for the erection, as soon as funds become available, of a woman's hospital on one side, and a children's hospital on the other.

A word or so may be said about the school itself before describing the new home. It has been the aim of the hospital management to place the school on the highest possible standard, inas-

much as it possesses the advantage of being part of a University, and entirely controlled by the medical department thereof. The school is thus in a position to draw on the medical department for teaching facilities, instructors, and opportunities for experience in clinic, out-patient, obstetrical, and social service work.

With these facilities at its command, the school is making a steady effort to develop along lines which will make it attractive to college women, and to those who may be interested in hospital teaching and administration in social service and public health work.

The first step taken to place the school on a high educational basis was to establish in the University curriculum, a three year pre-nursing course which, combined with two years spent at the Stanford School of Nursing, permits college women to

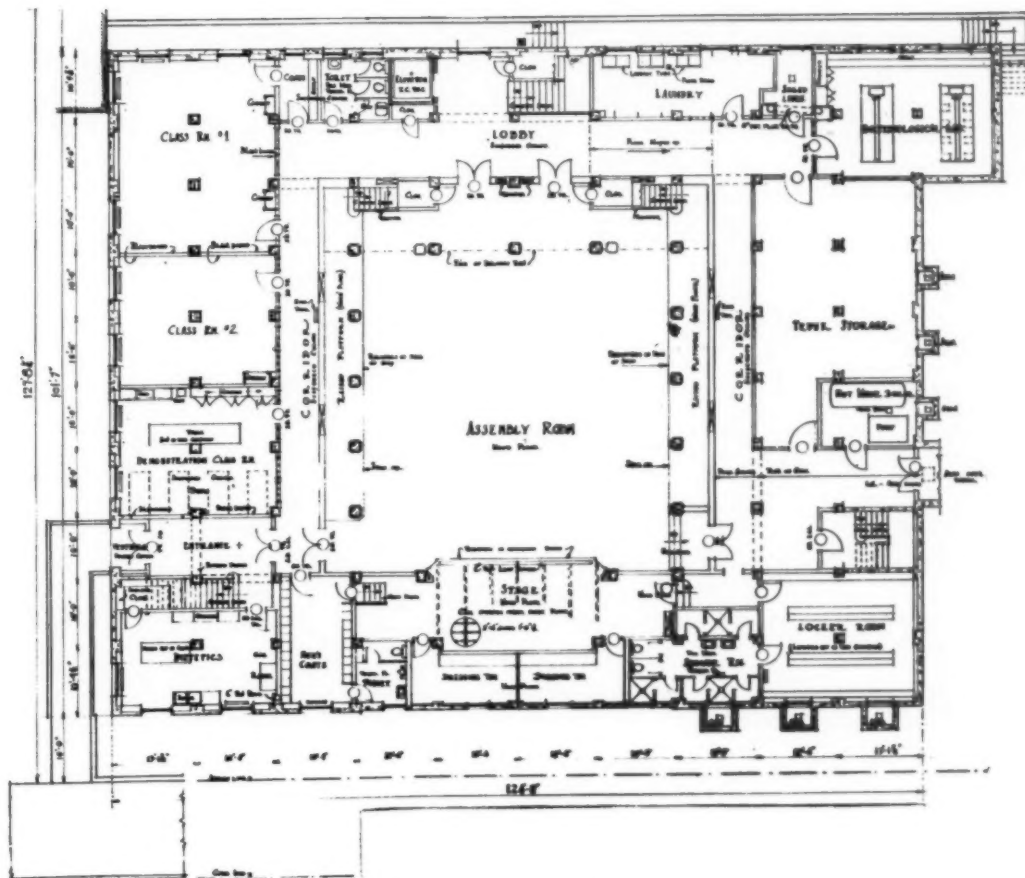
obtain the degree of Bachelor of Arts and Graduate in Nursing, at the close of the five years.

The second step was the recognition of the instructing staff of the training school as members of the university faculty. The following have been elected members of the faculty: superintendent of nurses, Miss Elizabeth Hogue, A.B., R.N., with the title of professor of nursing; Miss Maud Muse, R.N., instructor in theory and practice of nursing; and Mrs. Hazel Smith, R.N., instructor in practical nursing.

In planning the new building it was considered that something more than a dormitory was neces-



This attractive building is the new home of the Stanford School of Nursing.



Ground floor plan of the Stanford School of Nursing.

sary. Accordingly, special effort has been made to provide ample accommodation within the building for instruction, recreation, and a broad social life. The structure provides not only rooms for two hundred nurses, but also class rooms, laboratories, assembly hall, gymnasium, social quarters, and an infirmary. The extent of these provisions may be judged by referring to the accompanying plans and the description given below. As emphasis has been laid on the educational facilities, the building has been called the Stanford "School of Nursing," rather than "nurses' home."

The building is situated directly opposite Lane and Stanford University hospitals, and is connected with them by a large tunnel running beneath the street, by which the nurses may pass back and forth without exposure.

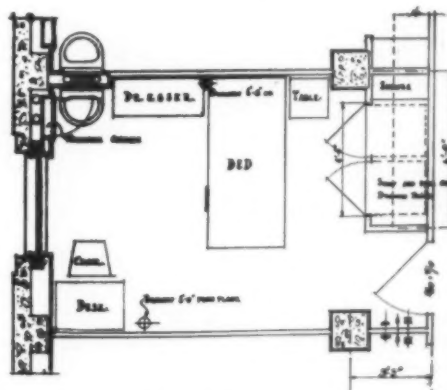
Arrangement of the Ground Floor

The building is constructed of reinforced concrete and is practically fireproof. It consists of two wings of seven stories, each facing to the south, the north ends of which are connected by the main portion. The space between the wings corresponding to the ground and first floors is occupied by the assembly hall with a skylight over it.

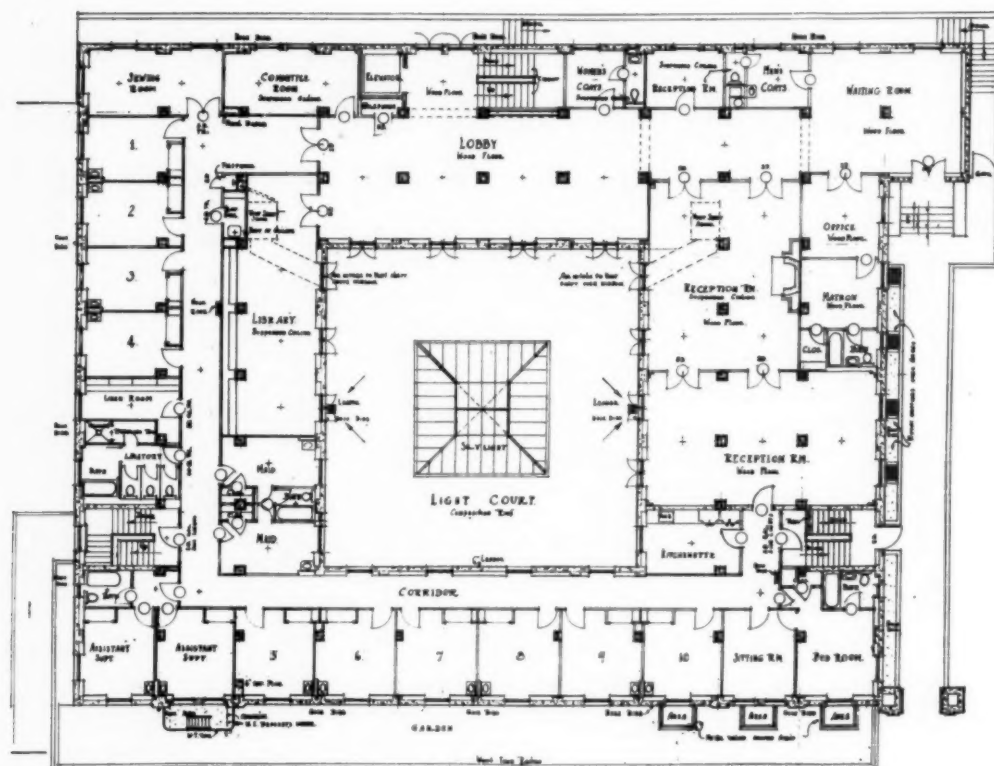
Access to the ground floor is provided by a

separate entrance from the street and also by the main tunnel from the hospital. On this floor are situated two large class rooms, a demonstration room, dietetic laboratory, chemical laboratory, and a large assembly hall with stage. This hall is so arranged that it may be used for dances, lectures, and gymnasium purposes. Adjacent to the hall are lockers and showers. Space for trunk storage, and a hand laundry for the personal use of nurses is also provided on this floor.

The social life of the nurses will be largely centered on the first floor. At the entrance is a good sized waiting room with adjacent men's coat room, women's coat room, and small reception



Plan of typical room.



First floor plan of the Stanford School of Nursing.

room. The entrance lobby leads then into a large reception room with a fireplace. Adjoining this is a third reception room of large size to be used as a music room. These reception rooms open into one another and have hardwood floors, and are so arranged that small dances may be held here, while the larger dances will be given in the assembly hall.

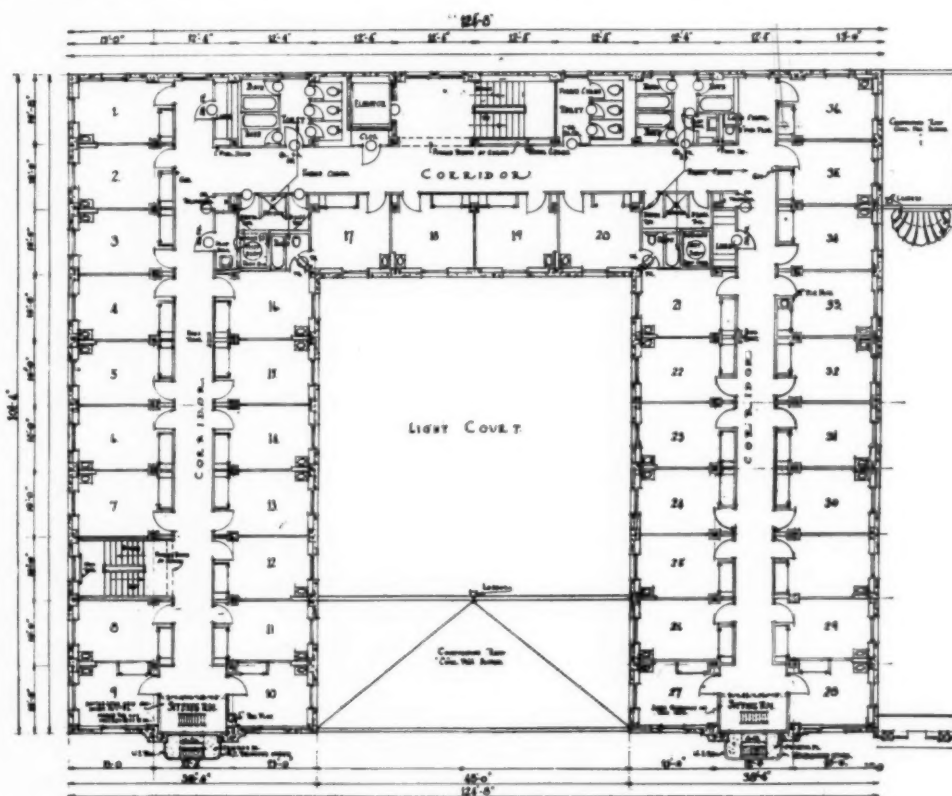
Passing on from the entrance lobby, the large main lobby leads to the library and also to the committee rooms, sewing rooms, elevator, and stairways. There are also situated on this floor an office, house mother's quarters, a few single rooms, and the suite of the superintendent of nurses.

The second, third, fourth, and fifth floors contain each thirty-six single rooms. There are no double rooms. The toilets, tub and shower

baths are situated on the cross corridors at the north side of the building. At the south end of each wing corridor there is a sun room.

Special attention may be called to the nurses' rooms, which will have every possible provision for the comfort and convenience of the occupants. Each will have hot and cold running water, a clothes closet, bed, bedside table, rug, easy chair, study desk, and desk chair. One electric light will be placed between the bed and the dresser, and there will be another one over the desk. The fixture selected provides for locking the lamp so that the outlet may not be used for other electric apparatus.

All corridors and bedroom floors will be covered with linoleum cemented to the concrete



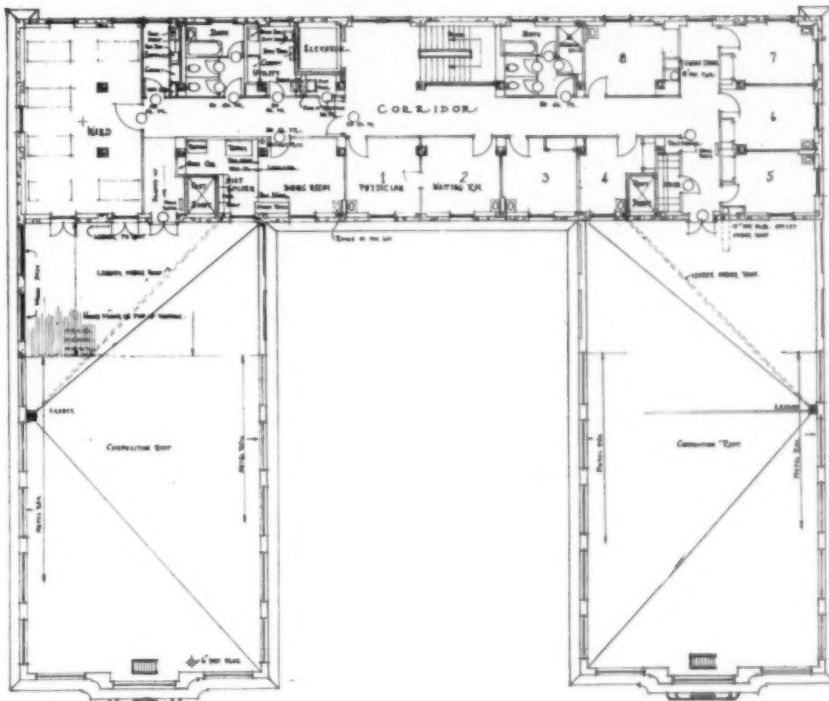
Second floor plan of the Stanford School of Nursing.

beneath. The assembly hall and reception rooms will be covered with hardwood flooring; and baths and toilets will have tiled floors.

Adjacent to the roof garden an extension of the main building will provide a ward of six beds with adjacent utility, supply rooms, and kitchenette. Treatment, waiting, and consulting rooms are also to be situated on this floor for the use of the nurses' medical attendant, and for keeping the morbidity records.

The telephone system within the hospital will save time and energy. A switchboard in the matron's room is connected with the main switchboard of the hospital. The local switchboard is connected with two telephone situated on each floor. When a

call for a nurse is received, a buzzer is sounded in the nurse's room. If present, she pushes a



Seventh floor plan of the Stanford School of Nursing.

reply button and then goes to the nearest booth to answer.

THE HOSPITAL LAUNDRY AND FABRICS*

BY WALTER TRIMBLE, CHICAGO, ILL.

WHEN an article comes back to the hospital's clean linen room, after being laundered, any hole or rent that may be in the piece will, as a matter of course, be attributed to the laundry department. The fact that even the best of fabrics is bound to wear out at some time or other is forgotten, and it is seldom remembered that sometimes the goods are damaged in the hospital, either by employees or by patients. The laundry may cause some destruction of fabrics, and it cannot avoid wearing out the goods to some extent, but nevertheless it should not be blamed for sins which it does not commit.

A letter that has just come to me shows the manner in which many pieces of valuable goods are ruined in the wards of hospitals. Parts cut from two articles were sent as samples, and each had a round hole in it. To the uninitiated it would appear that each of these round holes had been cut with a sharp instrument. But neither hole was made in that manner.

The first piece was of muslin, and in it was a circular hole, about three and a half inches in

diameter, and with it was the circular piece which had been cut out. When this latter piece was fitted into the hole, about one-eighth of an inch space remained all around. The writer of the letter explained that these holes were constantly appearing in goods sent to the hospital's laundry from the wards, and he also stated that the holes had never been found in goods which came from the nurses' home.

This gave me a clew to the cause of the holes, and a chemist later confirmed my opinion. The holes were not the fault of the laundry. Circles were eaten into the fabric in the hospital, and in the following manner: A great many of the antiseptic solutions which are used in a hospital will destroy cotton and linen fiber. Sometimes the bottom of the vessel which contains a solution will become moistened with the liquid, and then it is set down on a piece of goods. If the bottom of the container is concave, as is usually the case with a cup, a glass, or a bottle, this weakens a narrow circular path, and then, when the article goes into the washing machine, the weakened fiber comes out, and a round hole is the result. The damage, in such cases, is done in the hospital, but the laundry gets the blame.

*This is the sixth of a series of articles, by Mr. Trimble, on the hospital laundry. The others have appeared in the November and December, 1920, and the January, February and April, 1921, issues of THE MODERN HOSPITAL.



STATE HOSPITAL LAUNDRY, NORRISTOWN, PA.

An artistic and unique building, in beautiful surroundings, which makes an ideal laundry home. All of the machinery in this plant is electrically driven, eliminating all belting and overhead shafting.

The other piece was a towel, and the fabric was not eaten through all around, but it was penetrated in five spots. Put a corrosive antiseptic solution on the bottom of a common water glass, pick up a towel, and wipe the moisture from the glass, pressing with your thumb and four fingers, which is the most natural manner, and you will reproduce this condition.

A similar weakening of pieces of fabric often takes place in the kitchen. A heated dish or plate is taken from the warmer and placed on a napkin or tablecloth, and as a result it cooks the fiber with which it comes in contact. It is not an actual and visible "scorch," so the damage is not seen by the one who does it. But when the piece is washed, the cooked fiber comes out, leaving a hole. Or it may be a vessel direct from the stove that does the damage. At any rate, the laundry gets the credit—or, rather, the discredit—for the damage.

Defective and Adulterated Goods

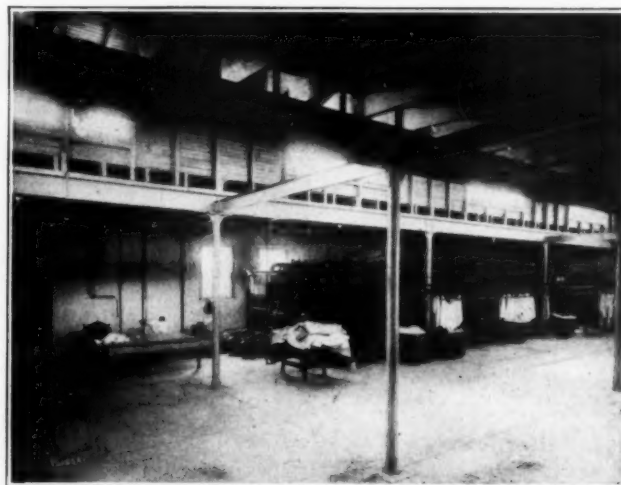
Sometimes one will purchase, in the interest of economy, fabrics which are seemingly offered at a very low price. If one does this, he is very apt to get material which is equally low in quality, if not lower. If I may offer a word of advice on this subject, it is this: Buy from none but reputable houses, keep quality in mind, and shun all so-called bargain offers. Do not make the common mistake of thinking that "the thickest goods will last the longest," for a piece of thick goods may be of short staple fiber, loosely woven, filled with sizing, and full of flaws, and therefore not having nearly the wearing quality of a much thinner piece. There are lots of adulterated fabrics on the market, and some are positively fraudulent, but I will not go into the details of these matters now. To guard against being deceived by such goods, one should buy only from repu-

table makers or jobbers, selecting brands which are known to be uniformly good.

Other Sources of Destruction

Other injuries than those I have referred to may be done to fabrics in the hospital, before they get to the laundry department. Where the pieces go to the laundry through a chute, there often is needless wear and tear. The sides of the chute may be rough, and thus goods may be ruined by abrasive action; or there may be a splinter, a screw, a nail, a rivet or something else projecting, which will tear the goods.

Where there is not a chute to the laundry department, it is often customary to do up large bundles of goods, with a sheet or tablecloth on the outside, to hold the articles together. Then, as the bundles are too heavy to carry, and as no truck is available, the precious package is dragged across a rough floor. Thus, a big hole is worn in the outside article, and perhaps the dam-



LARGE CONVEYOR DRYROOMS.

View in State Hospital Laundry, at Norristown, Pa. After being starched, various articles are hung on a conveyor chain, and as they pass through the heated chamber they are dried.

age extends to the inside of the bundle, as far as five or six layers of goods.

While the use of a truck may save articles in one way, it may destroy them in another. Very often, employees are allowed to place piles of goods on the floor. Then, a truck comes too near, the sharp wheels pass over a few pieces, cutting a gash in each one. This may happen in the hospital, before the goods go to the laundry department, but the laundry is more than likely to get the blame. The laundry is not always innocent, either, for this frequently happens in the washroom. Sometimes it is shoe heels which damage the goods, instead of truck wheels, and the damage may either be done in the hospital or in the laundry. Even the dainty French heel of a nurse, if applied to a piece of goods which is lying on a hard floor, will make the beginning of a very large hole. Remember, these dainty heels are often made of metal, and if the leather pad is worn off, they have a cutting edge. It is hardly necessary to tell what the hobnailed shoes of the men in the laundry will do to any articles on which they may happen to land.

It is obvious that goods never should be placed on the floor, under any circumstances, either in the hospital or in the laundry. Provide plenty of tables and platforms, and see that all soiled articles are placed on these. Be sure, also, that there are no splinters on these to tear the goods. Provide plenty of trucks and hampers and permit no dragging of bundles.

Another cause of mechanical injury to the goods in the washroom is "strong arm" practice in getting the pieces out of the washing machine. If the pieces have become tangled up, which often happens in the washing process, the "strong arm" washman may pull them out by main strength,



IRONING DEPARTMENT

View of the large, well-ventilated and well-lighted ironing department of the State Hospital Laundry, at Norristown, Pa. On the left are two large flat work ironers, on the right are two more, and at the rear are the smaller ironing machines.



A VERY LARGE WASHROOM.

View of the washroom of the State Hospital Laundry, at Norristown, Pa. Note the large over-driven extractors in the foreground, at the left, each with direct-connected electric drive. Like the ironing department, this has unusually good lighting and ventilation.

instead of first disentangling them so they will come out easily. If a machine is running as it should, the goods will not tangle, a slipping belt being the cause of this trouble.


Still another cause of mechanical injury to goods in the washroom is the improper loading of the extractor, which, as I have explained in a previous article, is a machine to remove the excess moisture by centrifugal force. If the load is not put into the extractor properly, there will be a strain on some pieces, and this may cause some to tear, especially the weaker ones. Here, as in the foregoing case, skill and care are required.

The damage done by over-washing, by which I mean washing too long a time, is from both mechanical and chemical causes, but as this is too long a subject to discuss in this article, I must leave it for a future one. Be sure that your fabrics are washed just long enough, and no longer.

All of the mechanical and chemical sources of damage should be reduced to a minimum, for, as all know, fabrics are still very expensive. This should be kept constantly before the manager of the hospital's laundry department, "lest he forget." But the hospital superintendent also should take particular pains to see that needless damage is not done to goods in the hospital itself. It is well to keep one's eye on the nurses and other employees, to see what damage is being done. Then see that safe and sane methods are used in the laundry.

St. Mary's Hospital, Waterbury, Conn., is planning an addition to cost about \$500,000.

The City of Erie, Pa., is having preliminary plans drawn for a municipal hospital, to cost about \$125,000.



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STAFF HOSPITALS MENACED IN FOUR STATES: A DANGER AND A DUTY

OF A sudden, the medical administrative policies of non-municipal hospitals have become a political issue in four states. In the legislatures of Missouri, Wisconsin, Illinois, and Michigan, at almost the same moment, as if by preconcerted agreement, bills have been introduced which are designed, either by the withdrawal of direct subventions or by the nullification of existing tax exemptions, to harass not only closed or staff hospitals, but those which, though open to all qualified medical practitioners, prudently draw a line against non-scientific cults whose practices menace the health and safety of the public.

In Missouri, as we go to press, such a measure has actually passed both houses and awaits the action of the governor. It is left for the governor to say whether, at this critical period in the financial history of all charitable institutions, hospitals are to be forced to choose between countenancing the pernicious practices of quacks, and paying the penalty of heavy and unprecedented taxation. If the Governor of Missouri is "from Missouri" in the popular sense, he will veto this vicious measure, for what is demanded by the Missouri legislature is nothing less than the sacrifice of indispensable scientific and ethical stand-

ards—standards without which hospitals cannot retain their self-respect or the respect of the communities which they are asked to betray.

The enemies of scientific medicine are everywhere. The note which has thus been sounded in four states, and sounded with special emphasis in Missouri, will be heard elsewhere. It is a signal which will doubtless rouse the hospitals and the more intelligent lay members of the community to successful resistance. The Missouri bill may be vetoed; or it may be approved by the governor and subsequently declared unconstitutional by the courts; or it may obtain, though it does not merit, the approval of both the governor and the courts. The answer of hospital trustees to the demand that they throw the cloak of hospital respectability around eccentric cults, some of which are ludicrous, and all of which are dangerous, should be an emphatic "No!" Hospitals are sacred community trusts, pledged to use the property and the opportunities which they control for the prevention and cure of disease and for the preservation of human life. If legislatures are so reckless, so blind, or so stupid as to deprive hospital trustees of the right, or to relieve them of the duty of choosing hospital staffs with care and discrimination, the wholesale withdrawal of conscientious men from hospital boards will inevitably follow. Furthermore, those who now contribute to the support of free work in charitable hospitals will be justified in refusing to contribute another dollar to any institution which abandons its patients to the mercies of uneducated healers.

Not the least disconcerting part of the onslaught on hospital standards is the fact that in some instances the menacing legislation is supported not only by unreasoning devotees of disreputable dogmas, but by educated medical men who are filled with resentment against hospitals because under the staff system they are deprived of full hospital privileges. To the former, slow but indispensable educational processes are a nuisance; they clamor for the obliteration of all marks by which real medical qualifications can be distinguished. The latter demand only equality of opportunity for all reputable medical men. We have indicated the manner in which the demand of the first named group should be met by hospital boards and by the contributing public. The reply of hospitals to the second group must, however, be couched in different terms. If any real grievance exists, it must be frankly admitted and fairly dealt with.

None will deny the need of a system of medical education; no fairminded man will refuse to concede that medical students, graduate as well as

undergraduate are entitled to be taught by the ablest men that can be obtained. If the development of competent clinical instructors can best be accomplished by conferring special hospital privileges upon a relatively small group, such privileges should be conferred, not as a favor to the group immediately benefited, but in the best interests of the medical profession and of the nation. Herein lies the justification of the closed or staff hospital.

Those who are honored by staff appointments must recognize their obligations and do their duty. The staff of the closed hospital must teach. It must teach undergraduates in hospitals which are attached to medical schools, teach interns in hospitals which are fortunate enough to have interns, teach non-staff physicians everywhere. The closed or staff hospital is bound to maintain a grade of practice above the average, and to use its special opportunities and privileges in the broadest manner consistent with the safety of its patients and the welfare of the community.

The staff hospital must be a research hospital as a matter of course, for it possesses by far the best opportunities for the systematic study of disease. The members of the staff must be chosen for their ability to work at the bedside or in the laboratory, individually and in team formation. The hospital staff must ceaselessly practice self-criticism. It must work in the open, thus unequivocally demonstrating its sincerity of purpose. As a matter of practical necessity, the bulk of the medical profession must be excluded from membership in the staff organization, but no educated medical man may properly be excluded from its benefits.

The hospital staff must be prepared, at all times, to assist the general practitioner in diagnosis and treatment. The general practitioner should be invited to witness the treatment of his patients in its wards and operating rooms. Both clinical and pathological conferences should be thrown open to him. Courses of lectures and demonstrations should be instituted for his benefit. In brief, the staff hospital is charged with the duty of maintaining contact with the general practitioner and of keeping him constantly aware of and interested in its work and progress, and this is perhaps the only way in which the excluded general practitioner can be effectually and permanently separated from his present unholy and damaging alliance with the enemies of scientific medicine.

The staff hospital can best serve the practitioner, not by abandoning its exclusive form of organization, for this is indispensable to the maintenance of proper clinical standards in research, in teaching, and in medical progress gen-

erally, but by making its organization function with maximum efficiency. By doing its full duty, the staff hospital may avert a public calamity and a national disgrace.

HOSPITALS TO SHARE IN BUILDING REVIVAL

THE inability to provide adequate hospital facilities due to building conditions arising out of the war, has in many communities caused untold suffering, and not infrequently loss of life. There is increasing evidence, however, that conscientious efforts are being put forth to revive the building industry. Hospitals would of course share in such a revival, and in time the present deplorable situation in the hospital field would be changed.

One very significant piece of evidence is the National Construction Conference which was held in Chicago March 2 and 3, under the auspices of the National Federation of Construction Industries, at which some important resolutions were adopted.

After disclosing the facts that the cost of construction materials remains high when compared with prices before the war and the present average of other commodities, that the labor cost of construction has not been properly adjusted to present conditions, that the present conditions surrounding the financing of building construction must be modified, that the relations between employer and employee should be stabilized in order to secure continuity of operation and maximum production, and that employers in the construction industries have not acted promptly enough in effecting deflation of values, the Conference called for certain definite lines of action. It asked the manufacturers, producers, and distributors of building material to take such further deflations at this time as may be possible, and then to announce selling prices in which the public may have confidence, explaining to the public at the same time the elements of increased costs over which the manufacturer has no control.

It called upon building contractors to create a basis of labor cost on which the building industry may be re-established. To this end, it suggested that wages be readjusted, that irregularity of work, due to jurisdictional questions and sympathetic strikes, be eliminated, that efficiency and production be improved, that waste of effort be eliminated, and that employers readjust their overhead expenses and profits to conform to present conditions.

It called upon financial interests to accept a recession in profits and make liberal provisions for financing building construction.

It urged transportation companies to eliminate inefficiency of operation and reduce expenses in order that they might proceed with necessary construction work and reduce transportation rates on construction material.

It called upon mine owners and operators to improve their method of mining and marketing, eliminate waste and adjust labor rates, in order that the cost of fuel, an important item in construction, may be substantially reduced. It requested the Federal Government, and various states and their subdivisions, to eliminate unnecessary expense and practice the greatest public economy in order to reduce the tax burden. This reduction is necessary before there can be sound prosperity in industries, including the construction industry, which, next to agriculture, is the largest in the country.

And finally, it called upon all organizations and individuals connected with the building industry not to enter into, or make any arrangements that would tend to injure the public or increase the cost of construction unnecessarily.

In order to secure action on the declaration of the Conference, local chambers of commerce and similar community organizations were asked to assist in restoring the construction industry to a sound economic basis. The National Federation of Construction Industries was asked to appoint a central direction committee to act in executive capacity in carrying out the declarations of the Conference, through local conferences and cooperation with national organizations.

While the action of this representative body of construction industries as outlined above is bound in itself to have a salient influence on building activities in this country, including, of course, hospital construction, nevertheless the full success of the movement thus inaugurated will depend very largely on the spirit and earnestness of local effort. All who are interested in hospital construction, either directly or indirectly—contractors, building committee, trustees, and superintendents—should cooperate with the National Federation of Construction Industries as represented by its central direction committee, in furthering the movement for the revival of the construction industry inaugurated at the National Construction Conference.

LEGISLATIVE ACTIVITY ALONE JUSTIFIES STATE ASSOCIATIONS

STATE and provincial hospital associations now exist in thirteen or fourteen states and provinces of the United States and Canada. One of these associations has been in existence for five years; the others for varying periods

within this five year limit. Do these associations and what they have thus far accomplished justify a nation-wide organization of state hospital associations?

A critical analysis of the activities and accomplishments of existing associations reveals a number of excellent reasons why every state in the Union and every province of Canada should support active state or provincial hospital associations. It is our purpose here, however, to dwell on but one of these, namely, the efficient mechanism offered by them through which united action may be taken on legislative matters. The present trend toward state supervision of health having for its goal adequate hospital as well as medical service for all, as embodied, for example, in the health center bill introduced in the New York State Legislature last year and reintroduced this year, will involve the enactment of many new laws vitally affecting hospitals. In state associations the hospitals of each state will have an instrument through which they can come to a common understanding on legislative matters and with which they can take not merely the defensive, and oppose pernicious bills that are inimical to the hospital's principal purpose, but the offensive, and not only foster good bills, but actually formulate and introduce bills that are wise and constructive in character.

That state associations can wield a strong influence in this direction is definitely established by the activities of the associations now in existence. During the past year, for example, the Ohio Hospital Association has formulated a legislative program including the promotion of certain definite pieces of constructive legislation looking to a more stabilized standard of hospital work. The Michigan Hospital Association, in cooperation with the Michigan Nurses Association, has prepared during the past year amendments to the laws governing the regulation of nurses, which provide for a class of assistants known as trained attendants. It also prepared a bill looking to the protection of hospitals from fraudulent information at the time of registration. During 1919-1920 the Illinois Hospital Association took active part in the defeat of certain bills which, in its judgment, were contrary to the general welfare of the sick, and in the passage of other bills which, in its judgment, were good and should become law. The Wisconsin Hospital Association, not yet a year old, has been doing some vigorous legislative work in opposing certain obnoxious bills and in formulating legislation on fair payment for workmen's compensation cases.

There are, of course, a number of other compelling reasons why every state in the Union and

every province in Canada should have a state or provincial association. Some of these will be dealt with editorially in future issues of *THE MODERN HOSPITAL*. From what we have said, however, on the influence that can be wielded by state associations on state legislation affecting hospitals and public health, it would seem that the opportunity therein represented is ample reason, if there were no other reasons, for the organization of state and provincial associations.

BUY ON THE BASIS OF GRADES

A SUGGESTION that \$10,000,000 can be saved annually by the hospitals of this country is worth considering and acting upon. This is what Mr. Robert Bier, of the Bureau of Markets of the United States Department of Agriculture, says in his article on page 453, on the standardization of fruits and vegetables, that the hospitals can save in the purchasing of foodstuffs. How? By the adoption of a system of grades in obtaining supplies of fruits and vegetables, buying them on the basis of a definite standard, and seeing that the products delivered meet the requirements stated in the specifications.

The author points out that the United States Navy buys on the basis of definite specifications and through inspectors appointed by the Bureau of Markets sees that the products delivered meet these specifications. The inspectors at New York during a period of ten months, for example, accepted 8,337,493 pounds and rejected 273,263 pounds of foodstuffs, and cut 203,493 pounds from the weight of stock because it was in bad condition or improperly trimmed.

To the suggestion that hospital buyers may not have sufficient technical knowledge of the fruits and vegetables they are buying to apply grades to their purchases, Mr. Bier replies that the Bureau of Markets, which has offices in twenty-five of the leading cities of the United States, and authority to make inspection in one hundred and fifty-five other cities, will be glad to supply this lack of knowledge either by personal inspection or by suitable printed instructions.

In these days of the high cost of living, the hospitals owe it to themselves, to their patients, and to the public which supports them, to adopt every known method of economy in their management. The buying of foodstuffs as far as possible on the basis of grades is undeniably the most economical method of making purchases and should be more generally adopted. The Bureau of Markets of the United States stands ready to aid you along these lines.

BUILDING ORDINANCES AND HOSPITALS

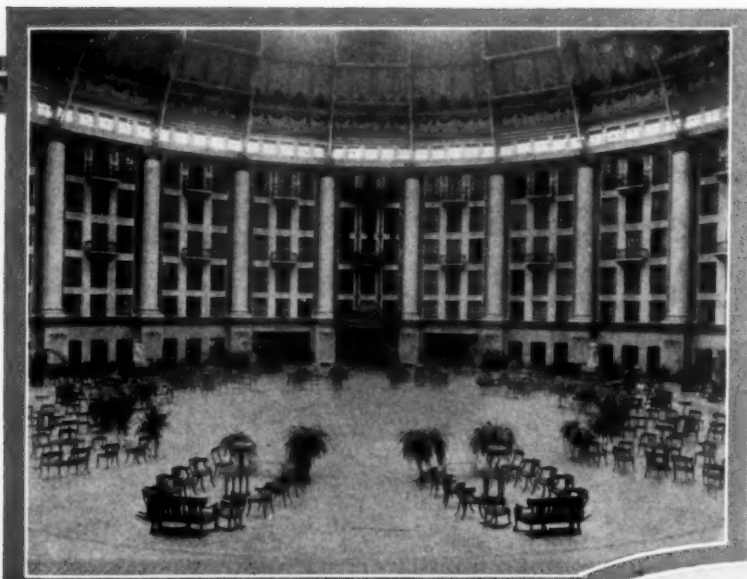
SOMETHING needs to be done to bring order out of the chaos that exists in the building ordinances of our various communities, as those ordinances relate to hospital construction. A glimpse at this chaos and utter disregard of economical and efficient hospital administration is given us by Dr. Hadden in his article on "Building Ordinances in Relation to Hospital Construction," (p. 414), in which he discusses particularly the ordinances of Oakland, Cal.

Despite the fact that in many respects this city has good building ordinances, not only from the point of view of general building, but also of hospital construction, it has a number of impractical provisions which would never have found a place there had the ordinances first had the benefit of the mature consideration of a group of qualified hospital executives and architects. He cites, for example, the provision which requires heavy swinging metal doors in fireproof buildings for stairway exits where the independent elevator hallway enters the main hall; also the provision which forbids a room for the storage and repairing of mattresses or furniture. Another provision makes it necessary to provide at least two complete suites of at least two rooms each for patients and nurse of patients affected with communicable diseases. These suites are to be in a separate building, or if in the hospital proper, are to be completely isolated from other parts, with entrances from the exterior of the building only. No provision is made for feeding the occupants of these rooms, nor is cognizance taken of the fact that the hospital may be a strictly surgical or maternity unit.

Undesirable provisions can doubtless be found in the building ordinances of all of our cities. Ought not steps be taken to eliminate them? As conditions vary in different parts of the country, this is a task that might very well be assumed by the various state hospital associations, through appropriate committees. Certain broad principles might, perhaps, very appropriately be established by the American Hospital Association.

GENERAL PERSHING URGES PHYSICAL EXAMINATION

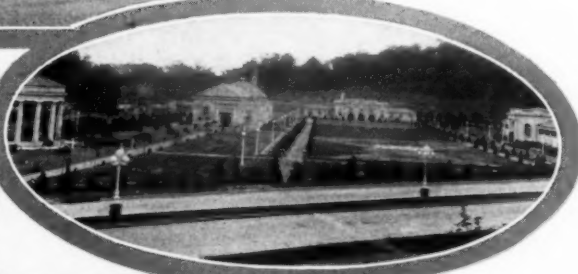
A campaign is being started for an annual physical examination for the young manhood of the country. The campaign is being endorsed by General John J. Pershing. The fact that more than 60 per cent of the young men drafted into military service during the war were physically defective accounts for General Pershing's desire for this measure. He feels that such an examination carried on by government officials, or private physicians under the authority of the War Department or the Public Health Service, would discover many remediable defects.



THE POMPEIAN ROOM



THE GOLF COURSE



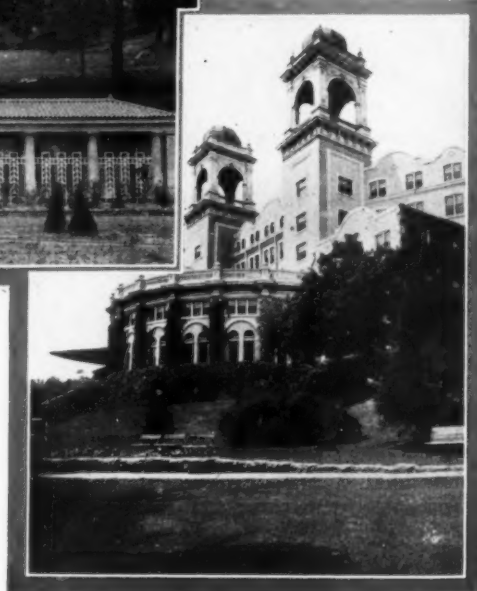
THE ITALIAN GARDENS



HYGEIA SPRING PAVILION



SPRUDEL SPRING PAVILION



THE NORTH ENTRANCE

A Group of Interesting Views of West Baden, Indiana, where the twenty-third Annual Convention of the American Hospital Association will be held on September 12-16, 1921

TAKING PRECAUTIONS AT THE TYPHUS HOSPITAL IN WARSAW

By FRANCIS W. PALFREY, M.D., TYPHUS RESEARCH COMMISSION, LEAGUE OF RED CROSS SOCIETIES, WARSAW, POLAND

TYPHUS fever is a disease which is particularly prone to attack physicians, nurses, and attendants who care for cases. Furthermore, it is a recognized fact that physicians so attacked usually have the disease in a severe form. The mortality among physicians, and especially among military surgeons, in the epidemic of the past two years in Poland, has been great. Yet more than in most diseases the method of transmission is understood, and preventive measures have been worked out by which the danger involved in the care of typhus patients should be rendered almost nil. Practical difficulties exist, it is true, which make it hard to enforce all necessary precautions in the stress of epidemics, and in the face of lack of supplies and equipment. Yet with proper methods systematically applied it is possible to carry out protective measures on a large scale on large numbers of patients.

Chief Purpose Study of Microorganism

The Typhus Research Commission of the League of Red Cross Societies had as its chief purpose the identification of the microorganism of the disease, and its study both in the louse and in the human being. To this end it was necessary to have access to a considerable number of typhus patients, so that they could be observed accurately throughout the course of their disease, and in fatal cases studied by autopsy. Investigation soon showed that even the best typhus hospital under Polish administration was too lax in its prophylactic measures to warrant the assignment of Red Cross nurses to work in it. The arrangement was therefore made that one division of this hospital should be put in the control of the commission and the American Red Cross, as a hospital within a hospital; and that such cases as we should select should be transferred to our service from other wards for the severest part of their course, and retransferred from our service as soon as they became convalescent. In this way we were able to effect a concentration under our care of the sickest patients in the hospital, and to retain these patients only during the active stage of their disease.

Plan of Division

The division of the hospital assigned to us was one of four contained in a large stone building of excellent hospital construction, completed shortly before the war. It consisted of a long entering corridor, opening on the left or southern side, upon a balcony, by high French windows and glass doors. On the right or northern side of the corridor opened a series of doors leading, in the order named, to the kitchen, two rooms intended for small

wards, but one of which was used by us as a nurses' dining room, and the other as a nurses' dressing room, storeroom, a hopper room, and a large patients' bathroom, used by us for admission, delousing, and a linen closet. From the further or western end of the corridor opened the two large wards, men's and women's, in wings of the building. On the left, close to the entrance to the corridor, were a bathroom (emergency laundry), and a toilet for personnel. From the hall, before the entrance to the corridor, opened a laboratory and a linen and sewing room. This space, it is to be explained, represented only the clinical department of the Commission; the bulk of the Commission's work was performed in the laboratories of the Hygienic Institute, some distance away.

All furniture and equipment was obtained from stores or purchased through the American Red Cross, since the hospital had lost almost everything during the German occupation. Our division was in the charge of Dr. Monroe A. McIver of the Commission, and myself, assisted by Dr. Naparalska, Miss Stella Mathews, chief nurse, twelve nurses, and four "Polish aides," student nurses, all assigned by the American Red Cross.

Dr. Aniela Apatow of the Polish hospital staff was assigned by the hospital to cooperate with us, and to keep records for the hospital of patients in our charge. Physicians were on duty throughout the day, and one made a later evening visit each night. Night emergencies were dealt with by the member of the Polish staff who was on duty, when requested by the nurses. The nurses were on duty in eight hours shifts. The three Polish orderlies, all of whom were

immune from typhus, also served eight hours each.

The patients were admitted only by transfer from other wards. They were selected as a rule from the sickest admissions of the previous day. No cases were chosen for transfer where the evidence of typhus fever was not conclusive. On admission to the hospital all had passed through a routine process of delousing, according to a well planned system, but it was plain from the start that the process was carried out in a perfunctory manner, since a large proportion were found to have nits and live lice still on them. Since, as can never be too strongly emphasized, a single bite of a louse from a typhus patient will produce the disease in any nonimmune hospital worker, it was therefore necessary to establish a louse-proof barrier between our division and the rest of the hospital. Thus on transfer to us all patients were brought on stretchers, kept outside of our division, straight to our delousing room. There they were stripped of all clothing, while still on the stretcher, and removed to the delousing table (a white-enamelled ready-made autopsy table drain-



The entrance to the wards at the Typhus Hospital in Warsaw, Poland. The large can at the door is the naphthalene can, in which gowns are placed as soon as they are removed.

ing into a pail hanging beneath, and fitted by us with white rubber pads). Then the stretcher, with all bedding and clothing brought with the patient still on it, was taken back to the ward from which it came. The patient was then inspected for lice, which were found most commonly on the head or in the pubic and anal regions. While the pubic or "crab" louse is not convicted of carrying typhus, true body lice were often found in the pubic hair.

The head, axillae, pubic, genital, and anal regions were then clipped close with barbers' clippers, supplemented as necessary by the safety razor, and a soap and hot water bath was given to all parts of the body except the head. The head was not bathed, since early in our experience we found that after bathing the scalp, drying it, and applying oil, it was still possible to comb live lice out of the deep layers of dandruff present on many of the patients' heads. We concluded from this that the water had prevented penetration of the oil, and thereafter ceased to bathe the head, depending instead upon clipping below the nit-bearing level, and upon oil, to kill lice in the scalp.

After the bath and drying, a mixture of equal parts of lightwood oil and kerosene was painted with a brush onto the scalp and about the genitals and anus, and rubbed less generously over the remainder of the body. The patient was then carried to his bed on a wheel stretcher kept in the corridor. The shaving and clipping was done on a white rubber sheet, to gather in all hair with possible nits and undetected lice, and which was carefully removed before the bath. The clippings were then transferred to a pail and boiled. The floors, which were of tile, were gone over with a kerosene mop after delousing each patient. The delousing of male patients was done by typhus-immune orderlies; female patients were deloused by nurses wearing the fullest protective dress, and instructed to inspect each other frequently. Both nurses and orderlies were closely supervised in this work by physicians, since in our opinion the greatest danger in typhus hospitals lies in the possibility of carelessness in the admission delousing.

Other Sources of Infection Found

Aside from the patients, other sources of lice had to be considered. All three of the orderlies and two kitchen maids were found to be louse infested, and had to be deloused. Linen from outside laundries was inspected before it was put away. While lice from such sources would probably not be dangerous until they had been transferred for a time to typhus patients, this possibility cannot be neglected.

In spite of these measures, which we believe to have been effectual in keeping our wards free from lice, it was nevertheless our practice to maintain precautions in our wards as if lice were known to be in them. To this end, physicians, nurses, and orderlies, on entering our division went directly to their respective dressing rooms and put on specially constructed louse-proof gowns. These gowns consisted of ordinary white surgical gowns sewed up the back so as to leave only the least possible opening behind the neck, with the addition of stocking-footed trousers closely sewed about the waist beneath the skirt. Large shoes or slippers were worn over the feet of these trousers. All seams were inspected for imperfections before a gown was accepted for use. The neck and wrists buttoned closely, and in all work, such as bathing or delousing, closely fitting rubber gloves were worn, and the neck and wrists of the gown were sprayed with cedarwood oil as a repellent. The nurses wore cloth head coverings

to confine the hair. All were cautioned to avoid unnecessary contact with beds and to be on the lookout for lice on patients, on bedding, and on each other's gowns.

On going off duty, gowns were removed at the door of the dressing room and placed in large covered galvanized iron cans. Each gown as it was placed in the can was sprinkled generously with flake naphthalene, and the gowns used in each tour of duty remained covered in these naphthalene cans for not less than twelve hours. Experimental boxes of lice placed among gowns in this process were found to contain no live lice when the gowns were taken out, showing the method to be effectual.

Precautions Prove Successful

As a result of these measures our whole hospital personnel, as well as others of the Commission, and visitors who came occasionally to our wards, all escaped infection. Moreover, except in the first days, before our method of treating the heads was improved, no lice were found in the wards.

Except for safeguards against louse transmission of



Louse proof gowns worn by the medical personnel in the Typhus Hospital.

typhus fever, there was little in the management of our service that was different from that of hospitals for other medical diseases. In all typhus hospitals delirium is encountered in many cases. The bars over our windows were all that prevented at least one patient from jumping out. Care of the mouth is more important and difficult in typhus than in most fevers, and precautions must be taken to guard against the transmission of the cause of suppurative parotitis from one patient to another.

Pressure, bruises, or cold extremities contain special danger of infection or gangrene. Certain special methods of treatment are still in the trial stage, but a majority of patients recover without treatment other than the ordinary hospital régime.

But in conclusion it must be emphasized that precautions against internal infection in typhus hospitals is not a mere luxury for the staff, but rather the first essential for the usefulness of the hospital. We were fortunate in being able to carry out the necessary precautions thoroughly, but most typhus hospitals have been less favorably situated.

Typhus a Disease of Epidemics

Typhus fever is essentially a disease of large epidemics, in times of disaster and privation. Too commonly, therefore, the typhus hospital is overwhelmed by great numbers of patients, with personnel, equipment, and supplies wholly unable to meet the demands. The overworked staff then fails to maintain precautions and its members soon come down with the disease. Then follows a stage when patients die in large numbers, not so much from the disease as from starvation, exposure, or thirst, being able to get even a cup of water only by the kindness of some other patient less ill than themselves. Thus the typhus hospital, without internal prophylaxis, may fail to serve its purpose as a hospital.

OCCASIONAL TUBERCULOSIS CLINICS IN THE STATE OF NEW YORK

By ELLIOTT WASHBURN, M.D., NEW YORK CITY

EARLY in 1918, intensive efforts on the part of the Tuberculosis Committee of the State Charities Aid Association of New York to encourage the establishment of additional tuberculosis dispensaries in the state and to increase the efficiency of those already in operation, emphasized a need in tuberculosis work which no existing agency met. This was the need of facilities for examination of the lungs by physicians especially qualified to make them in communities too small to have regular tuberculosis dispensaries, and which ordinarily were not so fortunate as to have resident physicians with any special training and experience in the diagnosis of tuberculosis, more especially in its early stages. Similarly, in such communities there was usually a lack of nurses trained in that special branch of public health nursing which is peculiar to tuberculosis. In small cities, towns, and villages, and in sparsely settled rural localities, it was difficult, if indeed not impossible, for persons in poor or very moderate circumstances to secure expert medical and nursing advice and service in tuberculosis. This may account for the somewhat large number of cases of the disease which have been disclosed by occasional clinics.

The Committee conceived the idea of securing the establishment of tuberculosis clinics in small communities, at which expert medical examinations would be provided at irregular intervals. The irregularity of the intervals at which they were held gave rise to their title, "occasional clinics." As the plan has developed in this state and extended in others, they have also been called "traveling," "itinerant," and "migratory" clinics. Whatever their name, their purpose is substantially as outlined.

The general plan of the Committee was to utilize to the fullest possible extent all tuberculosis agencies existing in communities in which clinics appeared to be needed, and to supplement through its own resources those of whatever individual communities could not for some reason provide for themselves, thus to make clinics possible.

Three Clinic Essentials

The three essentials for conducting an occasional clinic in a community are funds, a physician skilled in the diagnosis and treatment of tuberculosis, and nurses, of which at least one must have training and experience in public health tuberculosis nursing.

It was decided to inaugurate the experiment in Westchester County, because there existed in that county a number of fairly active local tuberculosis sub-committees of the Association's Tuberculosis Committee which had funds available for occasional clinic purposes, and because most of the communities of the county were near enough to New York City to render available the services of physicians expert in tuberculosis, and further because a number of the communities were fortunate enough to have public health nurses. Thus the three essentials for conducting such clinics were available. It remained for the Committee to bring to the attention of the several communities in which the need of occasional clinics appeared to be greatest, their expediency, and to outline to the several tuberculosis sub-committees the best method of procedure. This was the work of special agents attached

to the Committee's staff. It was agreed that the clinics would attract more patients and would be more favorably received by local doctors if the clinic physician was one of recognized ability in tuberculosis, and one not engaged in medical practice in the community served by the clinic. It was hoped to thus assure the local doctors that the clinic was in no way intended, or to be permitted, to interfere with their private practice. The local tuberculosis committee provided the place of holding the clinic, the rather limited equipment absolutely necessary, paid the examining physician, and provided the nursing service. The parent Committee sent one of the members of its advisory nursing staff to assist the local nurses.

Occasional Clinics a Success

The first occasional tuberculosis clinic was held at Harrison on May 15, 1918. It was a great success. Others were held in the county, the marked success of which attracted the attention of tuberculosis workers throughout the state and elsewhere. From this auspicious beginning in Westchester County, "occasional clinics" have become state wide. They have established their usefulness in communities which greatly needed them and which have suffered heretofore from their lack. They have brought to light the fact that much hitherto suspected but unrecognized tuberculosis exists in small communities, especially in rural districts, which have been feeding tuberculosis into the state much faster than the earnest endeavors of the larger communities have been suppressing it. They have come to stay, and mark an epoch in the warfare against tuberculosis. They are practical, not expensive, and satisfactory.

As the work has extended over the state these clinics have been held and are now being held under the auspices of the state department of health and the State Charities Aid Association working jointly, and by both working separately, and by local communities working alone of their own initiative. All existing agencies are cooperating to make them successful—including private physicians, physicians connected with state, county, and local tuberculosis sanatoriums, and hospitals, and attached to the staffs of the state department of health, the State Charities Aid Association, and local tuberculosis dispensaries; state, county, local, and private tuberculosis, public health, school and child welfare nurses; and state, county, and local tuberculosis and public health agencies of all kinds; much valuable aid has been rendered by private individuals.

Since their beginning, these clinics have been held in more than 120 cities, towns, and villages in the state, at which more than 6,000 persons have been examined by skilled diagnosticians. A considerable number of patients were found to be actively tuberculous and many were classed as "tuberculosis suspects." The clinics have resulted in the admission of a considerable number of patients to tuberculosis hospitals and sanatoriums, in placing many under medical care and nursing supervision in their homes, in securing examinations of contact cases, in supervision of suspects through the medium of open air schools and preventoria, and in taking precautionary measures in cases of adult suspects.

Occasional clinics have been firmly established in New York State and have demonstrated their great value. They serve best those communities which are too small to have regular dispensaries.

Essentials for Conducting Clinic

The essentials for conducting an occasional clinic are (a) an active supervising tuberculosis agency; (b) a modest amount of money; (c) a clinic physician who is known to be expert in the diagnosis of tuberculosis in all its stages; (d) a nursing staff of which at least one must have training in the public health aspect of tuberculosis nursing. In the clinics of Westchester County all of these essentials were available. In clinics held in some localities of other counties one or more were available, but in many localities where it was deemed desirable to hold clinics, not even one of these essentials was available in the locality itself and it became necessary for some outside agency to supply all of them. This has been done in some instances by the state department of health, in others by the Tuberculosis Committee of the State Charities Aid Association, in others by both, in others by county tuberculosis hospitals, and again by local sub-committees of the State Charities Aid's Committee, or by local tuberculosis committees working independently.

An account of the manner in which a clinic is carried through may be of interest. Briefly, it is as follows:

The selection of a locality in which a clinic is desirable is usually an easy matter. When the place has been determined, a supervising nurse of the Tuberculosis Committee of the State Charities Aid Association, or of the state department of health, or of the especial agency which intends to hold the clinic, proceeds to the place in order to pick out suitable, available rooms for the clinic. All kinds of quarters have been utilized for clinic purposes—as public halls, city halls, town halls, churches, parish houses of churches, rooms of local health centers, hospitals, school buildings, private houses, fire stations, physicians' houses, hotels, dispensaries attached to manufacturing plants, court houses, ordinary dispensaries, and vacant stores—one clinic was held in the open air. Usually a place which can be made to serve the purpose is not difficult to find.

Procedure in Conducting Clinic

Prior to the arrival of the nurse, the state department of health notifies the sanitary supervisor (state district health officer) of the district of the pendency of the clinic, and he informs the local health officer and urges his cooperation. The state department of health provides the nurse with a list of all cases of tuberculosis reported for the five years immediately prior to the clinic. She also obtains from the local health officer information in regard to local cases within his official knowledge. The nurse needs not less than one week, preferably two weeks, to properly work up each clinic. She visits the addresses of all cases on the list which has been provided for her, in order to encourage the attendance at the clinic of contact cases. She also visits any returned tuberculous soldiers and sailors in the locality, in order to secure the attendance at the clinic of any of those who need examination and advice.

The state department of health sends to all physicians in the locality served by the clinic a letter stating the purpose of the clinic and urging them to attend. Similarly, the nurse visits every physician for the same purpose. Usually several local physicians attend the clinic, and in a number of instances the clinic examiner has

examined patients in their homes, when they were unable to come to the clinic, at the request of local physicians. This free consultation service has been a source of much satisfaction to patients and to physicians. To be sure, in a few instances a few physicians appeared to resent the coming of the clinic and its attending physicians as an intrusion upon their territory and a reflection upon their diagnostic and professional ability. Happily such instances are few, and they are far overbalanced by repeated instances of cordial and active cooperation on the part of local physicians. Publicity in regard to the advent of clinics and also as to the results of clinics has been obtained by wide use of the newspapers.

The expert examiners for clinics have been drawn from any available source: thus physicians in private practice specializing in tuberculosis, physicians attached to the medical staffs of tuberculosis hospitals and sanatoriums and dispensaries, or to the staff of the state department of health, or that of the Tuberculosis Committee of the State Charities Aid Association, have been utilized. Their compensation has been nominal in most instances. The medical superintendents of county hospitals have found that conducting the examinations of the clinics has served as an excellent medium for their own introduction to their counties, and has increased the use of their hospitals.

In addition to the value of such clinics in determining the presence or absence of tuberculosis is the fact that the examinations have disclosed many physical defects and diseased conditions not due to tuberculosis. These have been brought to the attention of the patients' physicians.

Work Does Not End with Clinic

An all-important thing to remember is that the work does not end with holding clinics. The most important work is the follow-up cases discovered at the clinic, in order to be certain that the cases are under proper medical, nursing, and home care; to secure admission to tuberculosis hospitals of patients needing such care, to insure the examination of contact cases, and in many other ways to promote a successful campaign against tuberculosis. The nurse usually stays for a few days after a clinic and subsequently revisits the locality for follow-up work, providing no local tuberculosis or public health nurse or county tuberculosis nurses are available for this work.

A meagre equipment only is really essential. It includes a desk or table for the nurse, a supply of chairs, scales which usually may be borrowed, thermometers, wooden tongue depressor, paper handkerchiefs, clinic record charts, a small table and a chair for each examining physician, and a revolving stool in each examining room. A piano stool is always available and makes a very satisfactory examination stool. A couple of waste baskets are useful, and a few large paper bags are needed to receive soiled tongue depressors and paper handkerchiefs. A few sheets and towels are necessary; also a couple of white coats for the doctor, and some examination wraps for female patients. The physician needs his stethoscope. An instrument for determining blood pressure is often desirable. In few instances has it been practical or even possible to make x-ray examinations at the time of the clinic, but in numerous instances arrangements have been made so that such examinations were made subsequent to clinics, through cooperation between the regular medical attendants of patients and the nurses delegated to do the follow-up work of the clinic.

Objections have been raised to these clinics on the

ground that they are not sufficiently scientific, and that "suspects" found at the clinic are not reexamined sufficiently often to establish whether or not they are really tuberculous; and that the absence of x-ray facilities makes diagnosis impossible in some cases; in short, that they

are "too primitive." To some extent this criticism is just. On the other hand, repeat clinics, which have already been held in numerous instances, careful follow-up nursing service, and the x-ray service which is now possible, should do much to allay this criticism.

AN EXPERIMENT IN THE EDUCATION OF ORDERLIES

BY ETHEL JOHNS, R.N., DIRECTOR OF NURSING, VANCOUVER GENERAL HOSPITAL, VANCOUVER, B. C.; ASSISTANT PROFESSOR OF NURSING, UNIVERSITY OF BRITISH COLUMBIA

THE organization and management of orderly service in hospitals, both large and small, has always been a serious problem in hospital administration. Many factors contribute to make it so. To begin with, orderlies have been, and still are in many hospitals, a poorly paid group, working long hours, sometimes indifferently housed and poorly fed. Most hospital administrators of ten or fifteen years' experience can recall the grisly cockroach haunted caves in the basement of the oldest part of the hospital which were styled "help's quarters." Small wonder, therefore, that a large labor turnover resulted and that there was an unduly large proportion of the down and out, drunken, and incompetent in the ranks of this service. This state of affairs was the more deplorable in view of the fact that competent orderly service adds very greatly to the comfort and safety of patients, and is a valuable adjunct to both the medical and nursing services.

Betterment Movement Started

But even in those days there were in the ranks men of a good type with a genuine interest in nursing care who were a tower of strength to overworked nurses, and a great comfort to patients. Some of these men have developed into the leaders of the new movement toward sounder education for their fellows. They saw clearly that if orderly service could be placed on a higher educational plane, a like improvement in the quality of personnel might result, such as had already been apparent in the case of nursing. Superintendents of nurses were, unfortunately, not always as sympathetic as they might have been, and consequently development has been somewhat slow, but experiments are now being made in various parts of the United States and Canada which signify a brighter outlook for the future. Possibly the experiment now being conducted in the Vancouver General Hospital, British Columbia, Canada, may be of interest to hospital administrators contemplating development along these lines.

This thousand bed hospital has a very active service, a large proportion of which is devoted to the care of male patients. Since no medical school exists in the province, medical students are not available as assistants, nor is there a very large intern service. This means that a large number of orderlies must be employed. The usual faults of the old fashioned orderly service were painfully apparent under such conditions, especially as the shortage of interns incidental to the war made it necessary for these men to undertake procedures and treatments far beyond their powers, unless thorough and systematic instruction was afforded them.

Six Months' Course Given

This hospital is fortunate in possessing a chief orderly, Mr. G. A. McConnell, who combines good administrative ability with marked interest in teaching. With the con-

sent and cooperation of the general superintendent, Dr. Malcolm T. MacEachern, a six months' course for trained attendants was initiated in November, 1919, by the director of nursing and the chief orderly.

The curriculum was as follows:

Subject.	Periods	Instructor
Instruction in practical male nursing procedures (demonstrations).	Twenty	Chief orderly.
Instruction in first aid methods.	Eight	Resident staff physicians
Elementary anatomy and physiology.	Six	Director of nursing.
Drugs and solutions.	Six	Instructor of nursing.
Ethics.	Two	Director of nursing.
Preparation and service of food.	Three	Chief dietitian.
Nursing emergencies	Four	Chief demonstrator of nursing.
Management of mentally disturbed patients.		General superintendent.

Arrangements were made with the local branch of the St. John's Ambulance Association whereby men completing this course were granted the certificate of that body, as well as the certificate of the hospital as trained attendants. A group of fifteen men who were considered suitable were selected from the sixty orderlies employed at that time. Of these, six dropped out during the course for various reasons, nine presented themselves for examination, seven passed very creditably and the remaining two are taking the course over again and appear likely to pass their supplemental examination. Of the seven who qualified, six are still in the employ of the hospital and are serving in such departments as the operating rooms and the genito-urinary department, where unusual skill is required, and one man obtained a well paid and responsible position in a lumber camp in charge of first aid work. The stabilizing influence of the men who remained in the hospital on the other orderlies is remarkable. They are recognized as possessing superior qualifications and are treated accordingly.

Twenty Qualify for Similar Course

In November of this year it was decided to conduct a similar course and the whole orderly staff have been undergoing a sort of probationary period during which their fitness for training has been tested. This portion of the course is under the direction of the chief orderly, and is compulsory for all men employed as orderlies. Twenty out of a total of about fifty desired to take the full course at the close of this probationary period and came up for examination. A minimum mark of 80 per cent was required in order to qualify. Fourteen obtained it and four came near enough to it to be eligible for a supplemental examination, so it is probable that the whole group of twenty will take the full course.

It is far too early to forecast results, but even at this early stage of what is frankly an experiment, certain

benefits are apparent. These men are raised in their own estimation by the fact that they are receiving instruction. Some inducement to them to improve themselves is afforded by the increased wage and the possibility of lucrative employment outside of the hospital. Above all, a certain *esprit de corps*, such as exists in the training school for nurses, is beginning to make itself felt, this has as its most noticeable result a better service to the patients. The labor turnover has been appreciably reduced and in consequence a better stabilized service has been maintained. These results, alone, it may be justly claimed, have justified the experiment.

Many criticisms of the course as it stands can be made. It can be claimed that it either teaches too much or that it teaches too little. It was most difficult to judge what should be included and what should be left out. The teaching throughout was of the simplest possible character, and the topics of the anatomy and physiology series will serve to illustrate what pains were taken to make the instruction such as could be readily grasped and understood. The topics were: (a) The human body: What it is made of and how it is divided; (b) The skeleton and the joints; (c) How the blood circulates and why; (d) How we breathe; (e) How we use our food; (f) The wastes of the body.

As will be seen by these titles, the phrasing used was of the simplest type, and illustrative material, including lantern slides, was utilized at every lesson. Sufficient instruction in drugs and solutions was given to enable solutions to be made and doses to be measured with accuracy. Instruction was not given in the use of the hypodermic syringe. The men were taught to set a tray attractively and were shown how to make simple liquid nourishment.

The practical demonstrations were, naturally, the most important part of the course, and every effort was made to render these men proficient in the care of genito-urinary cases. Special lessons in the anatomy of the genito-urinary tract were given them in order that they might grasp the rationale of the various procedures. While taking the course they were on duty as usual, much in the same manner as pupil nurses would be, and their practical work on the wards could be closely checked. They received full pay and maintenance throughout.

Possibly the most interesting mental reaction was shown in their response to the lectures on ethics. The writer frankly approached this subject with considerable diffidence, but taking her courage in both hands, plunged boldly into the subject. She had expected a respectful if somewhat cynical audience. She found a group of men deeply sensitive to ethical guidance and pathetically eager to demonstrate their willingness to raise the morale of their group. The nurse instructors who assisted were alike impressed with the earnestness of the men, whose attitude was most respectful and courteous. In fact, one of the results of the course has been to increase the mutual respect of the nursing and orderly groups, and to check rather than to encourage undue familiarity between them.

In view of the fact that there will be a growing demand by industrial concerns in this province for men possessing training of the nature outlined above, it would seem that we are justified in continuing our experiment. Our ultimate aim is to place the whole orderly service in this hospital on a training school basis, but it will probably be some time before this far-reaching change can be brought about. We feel that by so doing we shall provide a training ground for a group of men who would be most useful to the hospital and to the community under normal

conditions, and who might well, in times of epidemic or disaster, prove to be invaluable. Doubtless many other institutions are conducting like experiments. It would be interesting to compare and appraise them with a view to ultimate standardization and legal recognition.

RED CROSS CONSOLIDATES DIVISIONS

Dr. Livingston Farrand, chairman of the central committee of the American Red Cross, has announced certain changes in divisional lines in connection with the more economical operation of the Red Cross program. The number of divisions is to be reduced from thirteen to seven.

The Northwestern Division will remain as it is, however, until the other consolidations have been effected and the new system is well under way. Until the ultimate change affecting the Northwestern Division is made, the divisions will be as follows:

New England—Maine, Massachusetts, Rhode Island, Vermont, and New Hampshire, with headquarters at Boston.

Atlantic—New York, Connecticut, Pennsylvania, New Jersey, Maryland, and Delaware, with headquarters at New York City.

Lake—Michigan, Indiana, Ohio, West Virginia, and Kentucky, with headquarters at Cleveland.

Southern—Virginia, North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana, and Tennessee, with headquarters at Atlanta.

Central—Illinois, Wisconsin, Iowa, Minnesota, Nebraska, South Dakota, North Dakota, Wyoming, and Montana, with headquarters at Chicago.

Southwestern—Missouri, Arkansas, Kansas, Oklahoma, Texas, Colorado, and New Mexico, with headquarters at St. Louis.

Pacific—California, Nevada, Utah, and Arizona, with headquarters at San Francisco.

Northwestern—Oregon, Washington, and Idaho, with headquarters at Seattle.

In the new grouping, the New England Division will have the same boundaries as in the past. To the Atlantic Division will be added the states of Pennsylvania and Delaware from the Pennsylvania-Delaware Division, and Maryland from the Potomac Division. Michigan will be transferred from the Central to the Lake Division, and West Virginia, which has been in the Potomac, will become a part of the Lake. Virginia from the Potomac, and Alabama, Mississippi, and Louisiana, which have formed the Gulf Division, will go into the Southern. The Northern Division will be consolidated with the Central, and Wyoming, which has been in the Mountain Division, also will go into the Central. Colorado and New Mexico, which have been in the Mountain Division, will be added to the Southwestern. Utah, which has been in the Mountain Division, will be joined to the states in the Pacific Division.

ISSUES MONOGRAPH ON ANESTHESIA

The National Anesthesia Research Society has just issued a publication on "Nitrous Oxide-Oxygen Analgesia and Anesthesia in Normal Labor and Operative Obstetrics." The society believes that it has here the most authoritative word in the literature of the subject covered. The publication committee was composed of ten men practically all of whom are men of national reputation in their special line. The editor was Dr. F. H. McMechan, who is well known to all who are familiar with the history or use of anesthetics.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
122 W. 85th Street, New York City

EDUCATION VERSUS TRAINING

By ANNIE W. GOODRICH, ASSISTANT PROFESSOR, DEPARTMENT OF NURSING AND HEALTH, TEACHERS' COLLEGE, NEW YORK CITY; DIRECTOR OF NURSING SERVICE, HENRY STREET SETTLEMENT, NEW YORK CITY

A RECENT call to deliver an address on nursing education was accepted with some mental perturbation, through the indication that an attitude still prevailed toward the subject, on the part of those concerned, that, with the developments in the fields of education, science, and health, should, it would seem, have disappeared. The urging of emphasis on the relation of the nurse to the doctor; a gentle caution of restraint in discussing the required body of theory; the reappearance of the "overtrained nurse," a characterization once popular but that has gradually faded out; all conspired to arouse this apprehension. Subsequent events, however, did not justify the preliminary anxiety. A group of some twenty graduates of the Teachers' College, Columbia University directors, and instructors of schools of nursing and nursing organizations, gathered together at dinner. An attentive and seemingly interested audience was reassuring, while the revelation of a notably progressive and extensive program of nursing education, with good promise of its early launching, was revivifying indeed. It proved a day of happy and inspiring episodes. Nevertheless, that day has resolved itself into the insistent question—"Does, after all, any appreciable part of the community yet grasp the significance of the increasing dissatisfaction of young women with our training schools for nurses?"—and a haunting memory of a row of newborn babies in the grim ward of the venereal department of the municipal hospital of that city.

Contemplative knowledge, Dr. Dewey informs us, has been superseded, "through the demonstrations of science that knowledge is power to transform the world," by practical knowledge.

"Nowadays, if a man, say a physicist or chemist, wants to know something, the last thing he does is merely to contemplate. He does not look, in however earnest and prolonged a way, upon the object, expecting that thereby he will detect its fixed and characteristic form. He does not expect any amount of such aloof scrutiny to reveal to him any secrets. He proceeds to do something, to bring some energy to bear upon the substance to see how it reacts; he places it under unusual conditions in order to induce some change."

We know today with an almost mathematical certainty the physical unfitness that can be found in any given unit of population. Various reliable authorities have reported figures. We are informed, for instance, that in a unit of

population of 100,000 there would be approximately 2,000 constantly sick, 1,000 suffering with tuberculosis, one out of eleven would be potential mental cases, one to ten would be the ratio of venereal disease. The weekly health index from the Department of Commerce, Bureau of the Census, informs us of the variations in the infant mortality rates throughout the United States. New York's is lower than some smaller industrial towns, but still higher than London's report for 1920, seventy-five per 1,000 births.

We know today with a hardly less mathematical certainty the percentage of these conditions that can be remedied, a large one, and the percentage, even larger, that can be prevented.

Whatever the future may bring, every health program today, whether for war or for peace; whether Federal, state, county, or municipal; whether dealing with the remedial aspects of the situation through the various institutions and organizations for the care of the sick, or dealing with preventive measures through various organizations and institutions such as schools, factories, and homes, demands in ever increasing numbers the worker designated as the nurse. The most casual observer of statistics issued by the visiting nurse service of the Henry Street Settlement for the year 1920, must be impressed with the opportunity of the nurse to function remedially and educationally in the community. In one year, nurses were called to 42,902 persons, and had 336,722 contacts with those members of the community most likely to be victimized by the defects of our social system, for no investigation has yet revealed that a majority of those who are unable to take their place honorably and effectively in the community are individuals of good physical condition and surrounded from birth with a reasonably good environment. Quite the contrary.

When curative medicine was seeking for a tool with which to apply its remedies, or surgery to carry out its technical procedures, the trained hands of the nurse, motivated by medical minds, functioned perhaps adequately, but the wider demands of the field of preventive medicine call for a different type of worker.

Under the caption "An Epitome," a student in the department of nursing and health, Teachers' College, writing of the essentials for the practice of nursing, in cryptic phrases portrays the nurse required today. Of this portrait we have but one criticism to offer, the inclusion of great enthusiasm as a requirement is redundant! The

1. Dewey—Reconstruction in Philosophy, p. 112.

absorption and assimilation of such a content of education as is suggested would supply, we believe, an unceasing stream of that emotion.

A change has taken place in the past few years in the attitude of educators, of the medical profession, and the public at large, toward this public servant, a greater change perhaps than even those who are most closely concerned in the developments in the fields of nursing realize. But is it through their awakening appreciation of the need of a different preparation for the fields for which the nurse is destined, or through the necessity of attracting young women in larger numbers to those fields?

The hospital, the greatest sufferer in the shortage, since it has depended so entirely on the student nurses, finding them an easy method of obtaining service at the smallest price, through the many fields now open for women, through easier means of self-support, and, above all, through its own failure to give the students a satisfying content of education, is obliged to accept the fact that some readjustment is called for since the former things have passed away.

Human nature, however, has not changed, "Man is possessed," says Veblen, "of a taste for effective work, and a distaste for futile effort. He has a sense of the merit of serviceability or efficiency, and of the demerit of futility, waste, or incapacity. This aptitude or propensity may be called the instinct of workmanship." The student mind, so illustrative of this instinct, has always been and still is indifferent to commercial ends except in so far as daily bread is imperative, or money is needed to procure mental satisfaction, and the student mind is increasingly with us. Thousands of young women, where formerly there were hundreds, are now going through the high school, thousands even are pressing for admission to our overcrowded colleges. Never in the history of the world were minds so eager for knowledge or so alive to the purposes to which it should be bent, and for that reason the call of the field of nursing should make the greater, not the less, appeal.

To quote again from Dr. Dewey: "In fact, the whole conception of knowledge as beholding and noting is fundamentally an idea connected with esthetic enjoyment and appreciation where the environment is beautiful and life is serene, and with esthetic repulsion and depreciation where life is troubled, nature morose and hard. But in the degree in which the active conception of knowledge prevails, and the environment is regarded as something that has to be changed in order to be truly known, men are imbued with courage, with what may almost be termed an aggressive attitude toward nature. Conditions and events are neither to be fled from nor passively acquiesced in; they are to be utilized and directed. They are either obstacles to our ends or else means for their accomplishment. In a profound sense, knowing ceases to be contemplative and becomes practical."

In those easy days of contemplative knowledge, the learned Diogenes out with a lantern searching for an honest man was probably a stimulating sight, but today, with science busy forging tools for the transformation of the world, Diogenes, to attract attention, would have to discard his lantern and apply his learning to the creation of an honest man.

Whatever the past may have accepted as adequate practice, the present, as a universal practice, is increasingly requiring that the hands be directed by their owner's head. In the November issue of the *Vassar Quarterly*

appeared two articles that give evidence, approached from different angles, of this fact. Under the title, "Do College Women Believe in Education?" Dr. Spalding of Yale deals with the question of a democratic use of education, while under the title "Workers' Education," is presented the effort of the workers to develop a program of higher education for themselves.

When, beginning with the kindergarten, we cease to teach competition for possession or advantage over others, and teach cooperation for a project, the carrying out of which calls for the creative ability of each, the new education will be assured.

Without perhaps a full awareness, the community is embarked on a great project, the creation of a one hundred per cent perfect human machine through which that energizing current called life can function to its greatest ends. Knowledge too precious to be put to such uses through every available human instrument should find its place with the jeweled crowns of discarded monarchs in the locked glass cases of a museum.

When the public grasps the fact that we are not seeking to elevate nursing into an aristocracy of learning, but to apply all available knowledge to this project through the nurse, numerically so strong a factor in the undertaking, there will no longer be this effort to cramp and stultify her education. And when the doors of knowledge are freely opened, students will awaken to the import of the nurses' task and will flock to our schools of nursing in far greater numbers than before.

NURSING JOURNAL ANNOUNCES NEW EDITORS

The *American Journal of Nursing* announces its new co-editors as Mary M. Roberts, of Ohio, and the present acting editor, Katherine DeWitt. As Miss Roberts is completing her second year of study at Teachers College, New York, she will not assume her new duties until August first. Miss Roberts graduated in 1899 from the Jewish Hospital, Cincinnati, and then became clinic nurse in the Erlanger Hospital, Chattanooga, Tenn., after which she went to Savannah, Georgia, where she established the training school of the Savannah Hospital, becoming its first superintendent. She did private duty nursing in Chicago for four years, and later held the position of superintendent of the Dr. C. R. Holmes Hospital, Cincinnati, for some years. During the war she was director of nursing of the Lake Division of the American Red Cross, then director of the unit of the Army School of Nursing at Camp Sherman. Since that time she has been studying at Teachers College. In association work Miss Roberts has been president of the Ohio State Association, and was a member of the Ohio Committee of Nurse Examiners.

From her experiences in various lines of nursing work it will be seen that Miss Roberts is well fitted for her new work.

INFLUENZA INCREASING

Influenza has been steadily increasing in New York City since the first of the year, although not reaching epidemic proportions. From January 1 to March 14 there had been 1,038 cases and 120 deaths reported. At present there are more cases being reported daily to the health department than at any time during the winter.

To be discontented with the divine discontent, and to be ashamed with the noble shame, is the very germ of the first upgrowth of all virtue.—Kingsley.

2. Veblen—The Instinct of Workmanship and the Desire for Excellence.

3. Dewey: Reconstruction in Philosophy, p. 116.

CONVALESCENT INSTITUTIONAL NURSING

By KATHRYN M. WOOD, R.N., DIRECTRESS, THE BURKE FOUNDATION, WHITE PLAINS, N. Y.

INSTITUTIONS for the care of convalescents are increasing. The next ten years promises to see very notable extensions in this field, as several large endowment funds are planning buildings and extensive services outside of our great cities. The provision for New York already includes general medical and surgical adult convalescents, cardiacs of all ages, and different degrees of disability, children of various age groups and types—and partial or beginning accommodation for the pre-tuberculous, orthopedics, psychoneurotics, with separate accommodation for different classes, such as pay-convalescents, the colored, etc.

It is estimated conservatively that there should be one convalescent bed to every ten hospital beds in a large city, the number varying with the living conditions and other factors. New York's requirement should be between 3,000 and 4,000 such beds. A fair average (considering all ages of inmates) is one nurse to twenty convalescent patients (including head nurses), which would keep more than a hundred and fifty nurses engaged in this vicinity alone. At the Burke Foundation ten nurses, including head, night and surgical nurses, care for three hundred patients; that is, one day nurse to forty-five or fifty patients. But the skilled supervision of convalescence is only beginning to be developed; there are indications of future special groupings which will demand more nurses per number of patients. And home convalescent care, though now credited mainly to standard social service, is steadily augmenting and separating, so that large numbers will gradually be enlisted in this health endeavor. It is evident that a considerable and increasing proportion of nurses in the large population centers will be needed in the convalescent field.

Convalescence may not, perhaps, be rightly called a nursing specialty as yet, but tends undoubtedly to become so, in measure with public health or industrial nursing. America is developing a new type of convalescent institution and home aid, which takes the patient earlier from hospital or clinic, completes wound healing, resolutely overcomes the prevalent border-neurasthenia, teaches food and hygienic good sense, provides heartening and hardening recreational and occupational exercises, plus a measure of pre-vocational training—and graduates the person (no longer a patient) into possibly handicapped, but often fuller life work and play.

Qualifications for this kind of nursing may well be indicated by a partial outline of the work. Patients come to us weak, introspective, disheartened, and with many prohibitions, fears and beginning invalid traits; the home desire is often strong upon them; they are hypersensitive, in a social mixture of much disturbing diversity. In some, the country quiet even augments an early depression or

homesickness. The nurse needs to make swift estimates of temperamental, racial and medical fitnesses, thoughtfully assign to rooms, and adroitly smooth and postpone many seemingly large difficulties. Then follows, during the succeeding days, the gradual adjustment to normal plain diet, occupational and recreational therapies, increasing outdoor exercise, mutual helpfulness and courage. It is notable that the homes providing this fuller reconstructive service are increasingly used for their mental and social therapies. Throughout this period, reconstructive both physically and mentally, the nurse finds constant demand for her best sympathy, tact, and judgment, in adjusting and alleviating an almost endless train of doubts, queries, minor complaints, etc. Nor is the higher nursing skill left in abeyance, for many of these patients have been most seriously ill and are subject to swift relapses and intercurrent disease. The majority of convalescent homes have a physician only upon call, and the nurse in this situation is peculiarly "the doctor," frequently deciding whether complaints and symptoms are of passing significance, or call for urgent medical attention.

As the convalescent emerges into fuller health and ambition the nurse's advice is sought on a wide variety of practical life questions, ranging from personal hygiene to the most intimate domestic and occupational problems. Lectures and demonstrations are frequently given on home and social betterment subjects.

Children's convalescence involves a specialized service, all the way from infant feeding to continuation schooling; yet the child convalescent is but a small edition of the adult, with kindred depletions, nerve

and mental imbalances; to be refilled and normalized by these environmental and personal influences. The responses of children and youth are ever more prompt and complete, which recompenses in some measure for the extra wear and fatigue of their supervision. The ratio of nurses is to be understood as increasing with the younger age groups, until one to every ten or fifteen patients is reached.

The trend of convalescent supervision in the institution, or at home, is definitely toward more elaboration, especially of the mental, occupational, and social therapies. The borders of this field are being extended rapidly, as in heart disease, psychoneuroses, the pre-tuberculous, nutritional disorders, preventive recuperations, etc. The increased costs and skilled attendance of this more refined and individualized service may in larger institutions be to some degree offset by the patients' assistance and leadership (highly restorative to the doer), such as is extensively developed at the Burke Foundation. Practical nurses, of exceptional qualifications, find limited place in this work, and may receive a partial training therein.



Nurses and patients playing golf.

Male nurses are rarely required, even where large numbers of men are accommodated; satisfactory attendants are readily drafted from among the patients needing long periods for recuperation.

From the viewpoint of the nurse, her ambitions and contentments considered, there are certain clear limita-



A supervised short-golf tournament and lawn-party at the Burke Foundation, White Plains, N. Y.

tions and advantages. Some of her higher technical skill (e. g., operating and sick-bed) gets little exercise, and a varying degree of detachment from the "leads" and associations of active city nursing occurs which may in many instances be undesirable. The reverse side has to do mainly with her health, and the gratification of seeing immediate and remarkable results. Though the directors of convalescent homes would perhaps not wish it generally understood that they accept handicapped aides, the fact holds good that the nursing staffs often include persons who have, in various ways through illness, operation, or nerve-fatigue, become somewhat depleted and distressed with high-tension institutional and nursing services, and seek recuperation, plus the satisfaction of agreeable occupation. The nurse herself invariably convalesces. The environment is charming and there is freedom from those stressful late afternoon hours that so drain energy; food is of the best; light exercise out of doors is a sure accompaniment; while an underestimated health intake results from the constant dealing with patients on the upgrade, patients being filled with new life,



It would be strange if anyone could keep from getting well with woods like these to walk in.

hope, and courage before one's eyes. To some, this country half-isolation may prove too pronounced, and these may return readily, with renewed spirit, to more energetic assignments.

The remuneration in convalescent institutions is always larger than at first appears. These plants have to become measurably and happily self-contained; hence much

personal upkeep, entertainment, etc., is afforded to the staff at low cost or free, and there is ever less incitement to expenditure. Nor does this service necessarily lead away from "a future." Directors and aides for the many new institutions are apt to be chosen from among these trained assistants; and not alone for the convalescent places, but for a large group of kindred institutions and health organizations which deal with handicapped, chronic, orphaned and "fresh air" thousands. Another and important outlet and interchange is via social service, public health, industrial and special clinic nursing, which have so many interlocking interests with convalescence. On return to private nursing it is found that higher skill in managing the convalescent period (the longer part of any illness) is a valuable asset. It is significant that nurses stay long in convalescent positions, and often return to them.

NEW REGULATIONS CONTROL NURSING HOMES

The *South African Nursing Record* for January announced that new regulations controlling nursing and maternity homes would come into force throughout the Union on April 1, 1921. By nursing and maternity homes is meant any premises where nursing is carried on for gain, not being an institution owned by the government or a Provincial Administration, a local or hospital board, or other public body. Any person conducting such a home must register it, and transmit to the Secretary for Public Health a duly completed application, the particulars of which will be registered by the Department of Health at Pretoria. The Minister may at any time authorize an inspection of these homes, a report of which must be made to the Secretary for Public Health. All records and information desired by the inspecting medical officer must be furnished to him by the home. A complete record shall be kept of all patients treated in the home, and a report of work done during the year shall be furnished to the Secretary for Public Health every year, not later than January 31.

These regulations are exactly what the Trained Nurses' Association has been urging for years. They will insure that homes are decently run, and will no doubt be of great benefit to those homes which are above suspicion, and will put out of the running many which are not.

IS NURSING REALLY LESS ALLURING?

"Many young women are choosing paths of lesser resistance and entering other fields that seem immediately more alluring. I am told that service in a hospital is no longer as attractive to them as formerly, possibly for a reason not unrelated to the emancipation and aspiration of modern womanhood. For not only does the nurse desire to develop herself professionally, but also individually, and, when off duty, to create for herself an environment and an atmosphere that perhaps are not regarded, in the unrest and yearning that are a phenomenon of the day, as adequately realizable under the residential limitation and disciplinary regulations of institutional life. 'The fault is not in our stars, but in ourselves, that we are underlings,' they seem to say."—1920 Superintendent's Report, Butler Hospital, Providence, R. I.

HONOR FOUNDER OF THE LIGHTHOUSE

Miss Winifred Holt, founder of The Lighthouse, an educational center for the blind, has been presented with a gold medal in recognition of her work among the blind of Italy during the war. The presentation was made in behalf of King Victor of Italy.

BETTER SCHOOLS AND BETTER TEACHERS, KEYNOTE OF NURSES' CONVENTION

By BLANCHE PFEFFERKORN, ASSISTANT PROFESSOR, SCHOOL OF NURSING AND HEALTH, UNIVERSITY OF CINCINNATI, CINCINNATI, OHIO

THE twenty-seventh annual meeting of the National League of Nursing Education was held in Kansas City, beginning on Monday morning, April 11, and closing Thursday, April 14. While the final business meeting occurred Thursday evening, the convention actually continued throughout Friday until six o'clock, for on Friday were discussed such important subjects as "Legislation and Inspection of Schools of Nursing," and "University Schools of Nursing." Practically everyone who came to Kansas City remained for the Friday sessions.

It would be exceedingly difficult to write a detailed report of the convention, because of the great crowding in of impressions, and the speed with which one session followed upon another, and the many topics presented. One fact, however, from early Monday morning till late Friday afternoon was so apparent, that no crowding and no speeding could lessen the force of its presence. The women who had assembled in Kansas City had come together to give and take, to the end that nursing education might be broadened and enriched. Among those present were many of the foremost nurse educators of the country, some of whom for years had given generously of their fine wisdom and rich experience. A second group was also evident, the younger members of our growing body of nurse educators. The enthusiasm of these younger members was one of the most encouraging notes of the session. Perhaps never in its history has the purpose of the League been more manifest than at this twenty-seventh meeting.

Probably one of the points most emphasized throughout the convention was the urgency of establishing in all schools of nursing sound educational policies. The world is moving onward. Emphasizing health and community fitness, it is asking of no profession to keep pace with its progress in a greater measure than it is of nurses. As pointed out by Miss Anna C. Jammé, the president, the nurse of the present and of the future must have an understanding of social problems; she must be an organizer, a teacher, an administrator, a leader, and an educator. Professor Charles Elwood of the University of Missouri, in his address "Training for Leadership," at the Tuesday evening meeting, declared that nurses made the best community leaders, and emphasized the expediency of preparing nurses for this capacity. If the nurse is to reach her fullest development and give the public that for which it is asking, the public must in its turn, give that assistance which will make schools of nursing, schools in the same sense as other schools.

Concretely, what are those things which nurse educators are asking in order that nursing schools may be really schools? This question was very ably treated in two papers read at the Tuesday evening meeting, one by Mrs. Ethel Clarke of the Indiana University School of Nursing, and the other by Miss Isabel Stewart of Teachers' College, Columbia University. Following are the points which were stressed: 1. Need of independent financial support for schools of nursing. 2. Lack of understanding on the part of the public and the medical profession of nursing needs; the public must be more informed and better informed of the fundamentals of nursing education, and

the requisites of nursing schools. It must learn to distinguish between a hospital as a place for caring for the sick, and as a place, constituting, complete and in itself, a school of nursing. 3. A sounder curriculum; (much has been accomplished in this direction since the publishing of the standard curriculum by the education committee of the League). 4. Adequate class-rooms, laboratories, and libraries. 5. Need of larger numbers of well qualified teachers in schools of nursing. 6. Increased relationships between schools of nursing and universities.

Apropos of the sixth item, it would seem fitting to note here the relationship of the schools of nursing in Kansas City to its Junior College. While not officially placed on the program, it would be safe to say that everyone who attended the convention was eager to learn the details of the Junior College and School of Nursing coordination. A large number visited the college to inspect its class-rooms and its laboratories. The writer interviewed Miss Helen Farnsworth, the nurse through whose efforts the arrangement has been largely effected, and obtained the following information:

Junior College is under the management of the board of education of Kansas City; it also receives a subsidy from the state. Its curriculum parallels the first two years of the Missouri State University.

In 1919, Miss Farnsworth, supported by the Kansas City League of Nursing Education, approached the board of education with reference to the teaching of student nurses those subjects included in the preliminary course of nursing. The authorities agreed to take over this responsibility and to follow the outlines prescribed for the preliminary period in the standard curriculum. The course of instruction covers three hours a day, five days a week, for a period of five weeks. The instructors concerned in the teaching of student nurses are paid on the basis of night school teachers, and in addition, their salaries are supplemented by the schools of nursing. The only other expense incurred by those schools within the city limits is a laboratory fee of \$2.50 per student. Schools outside the city are taxed \$5.00 tuition fee per student. At the present time eight nursing schools within Kansas City and two outside the city, are sending their preliminary students to Junior College. An average of thirty-five students each semester has attended the course.

While the main note struck at the convention was "real schools and better schools," its echo sounded back, "more teachers and better teachers." Opinion seemed unanimous that progress in schools of nursing, as in other schools, would in a large measure, be controlled by the development of their teachers. A number of round tables and one morning session were completely given over to the question of teaching. While much of the discussion centered around the technical aspects of teaching, the striking quality of these meetings, on the part of the teachers present, was the desire "to know," to have a rich knowledge of subject matter, and the ways and means by which such knowledge might be acquired. The sound of educational gatherings was in the air, several institutes were reported to have been held during the last several years, and a brief statement was made of one to take

place next summer in Ohio. The fact was cited that anyone could take regular college courses, either graduate or under-graduate, through the correspondence department of the University of Chicago, which courses are in every way the equivalent of regular courses taken in residence, and are given equal credit for a Bachelor's or Master's or whatever degree is being sought. This makes available courses in biology, chemistry, bacteriology, English, etc., for those instructors who, on account of short vacations, cannot be in residence for a full university session.

It is evident from the several preceding paragraphs that the teaching body of the convention was a live, active group, enthusiastic over what had already been accomplished, and eagerly looking toward greater things in the future. The direct outcome of the teachers' session was the formation of an instructor's section of the National League of Nursing Education, the declared purpose of which is a closer relationship among instructors, and the creating of a greater interest, particularly in young graduates, in teaching. Miss Nellie G. Browne, instructor at the Indiana University School of Nursing, was elected chairman of the section.

A report of the teaching program would be incomplete without a word concerning the paper written by Professor Albert T. Mathews of the College of Medicine of the University of Cincinnati, and presented at the Thursday morning meeting. This paper, entitled "After Twenty Years of Teaching," will be published shortly in the department of nursing education of the *American Journal of Nursing*. Let those who halt by the wayside and find the road of teaching steep and hard and rocky, read this paper; they will go on. For those who find joy in teaching, it is a song, the song each would sing over all the earth.

There were a number of round tables upon the special educational features of the public health nurse. On account of overlapping of sessions, the writer could not be present at these meetings, hence the impossibility of a statement of their results. A very excellent paper was read by Miss Edna L. Foley at the Tuesday evening meeting, on "Public Health Nurses." Miss Foley asked for "more nurses, better prepared nurses, fewer patients, and a better educated public."

As a very delightful surprise, Mrs. Helen Hoy Greeley appeared at the banquet Wednesday evening. Mrs. Greeley, who has been acting as council for the Missouri nurses, gave some of the details of the revised bill relating to schools of nursing in Missouri. At that time the bill had passed both houses of the legislature and awaited the governor's signature. Would the governor sign? During the days of the convention this question was heard again and again. The nurses visiting the state, as well as those resident therein, seemed equally concerned and anxious. Late Friday afternoon came the word that the governor had signed.

Not the least of the welcome features of the convention were those messages brought by Miss Clara D. Noyes, in a paper on "The New Interest in Nursing Education in Some Other Countries." Miss Noyes told of the schools of nursing which are being established by the American Red Cross, and the great need for modern nursing all over Europe. At another time Miss Noyes spoke of the splendid courage, the great endurance, and the ever present desire to do, of the American Red Cross nurse, no matter how difficult the situation, or how hopeless its outcome might seem. Is it not a fine thing to be a nurse? Her possessions are jewels of rare value, a great heritage, a present rich in service, and a future full of promise.

The officers of the National League of Nursing Education for the coming year are: president, Anna C. Jammé, R.N., State Board of Health, Sacramento, Cal.; first vice-president, Laura R. Logan, R.N., University of Cincinnati, Cincinnati, Ohio; second vice-president, Carrie M. Hall, R.N., Boston, Mass.; secretary, Martha M. Russell, R.N., University Hospital, Boulder, Colo.; treasurer, Bena M. Henderson, R.N., Children's Memorial Hospital, Chicago, Ill.

The directors are: Mary C. Wheeler, R.N., Chicago, Ill.; Annie W. Goodrich, R.N., New York, N. Y.; Amy M. Hillard, R.N., Troy, N. Y.; Effie J. Taylor, R.N., Baltimore, Md.; S. Lillian Clayton, R.N., Philadelphia, Pa.; Ethel P. Clarke, Indiana University, Indianapolis, Ind.; Mary C. McKenna, R.N., Columbia, S. C.; and Isabel M. Stewart, R.N., New York, N. Y.

INDUSTRIAL NURSES CLUB

Through the efforts of Miss Margery Lewis, a graduate of Presbyterian Hospital, the Industrial Nurses Club was organized in New York City, November, 1920. The organization was completed in February, 1921, when officers were elected and a constitution and by-laws adopted.

The following officers were elected to serve until the next annual meeting, May, 1922: president, Mrs. Frederick J. Brockway, Metropolitan Life Insurance Company, 1 Madison Avenue, New York City; vice-president, Miss Elizabeth Burns, Ladlew Tannery, Newark, N. J.; secretary, Miss Margery Lewis, C. Kenyon Company, Brooklyn, N. Y.; treasurer, Miss Mary Elderkin, Union Carbide and Carbon Corporation, 30 East Forty-second Street, New York City.

The club was organized for the purpose of stimulating interest in the special problems of the industrial nurse, and of providing a forum for the discussion of such problems. It meets the second Thursday of each month, from October to May, inclusive; dues are two dollars a year; and the active membership is limited to graduate, registered nurses, actively engaged in industry in Greater New York or vicinity. It is a live club, with already about seventy members.

For membership blanks and information apply to: (Miss) Margery Lewis, R.N., Secretary, 1919 Seventh Avenue, New York City.

STEEL CORPORATION ENDORSES HOSPITAL

Officers of the Reconstruction Hospital for the Rehabilitation of Industrial Casualties announced that the Carnegie Steel Corporation is the first large industrial corporation to pledge its support. The chief surgeon of the corporation, Dr. William O'Neill Sherman, telegraphed to the hospital authorities saying that the economic and humanitarian value of the hospital were easy to see, and that there would surely be in time one of these institutions in every large city of the country.

RESIGNS TO TAKE SECRETARYSHIP

Dr. William E. Musgrave has resigned as director of hospitals, University of California Medical Schools and Hospitals, San Francisco, Cal., and has become secretary of the Medical Society of the State of California, with headquarters in the Butler Building, San Francisco, Cal.

Drop the cant and treat sickness sanely. In dealing with the drunken we do not affect to be drunk. We must treat the sick with the same firmness, giving them, of course, every aid,—but withholding ourselves.—Emerson.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU GRAVES,
Home Economics Bldg., Cornell University, Ithaca, N. Y.

ATTACKING THE FOOD PROBLEM FROM THE RED CROSS HEALTH CENTER*

By E. A. PETERSON, M.D., DIRECTOR, DEPARTMENT OF HEALTH SERVICE, AMERICAN RED CROSS, WASHINGTON, D. C.

SOME three score years ago, Napoleon made the statement that armies traveled on their stomachs. Later one of our great American war heroes, Admiral Dewey, stated that it was his opinion that one-third of what we ate kept us, and the other two-thirds kept the doctors; and now comes along a real expert in the health field, particularly in the food field, and tells us that he can actually determine the length of life of certain groups of animals by feeding them in different ways.

Those statements, along with the results of recent laboratory and feeding experiments, have sensitized health workers to the importance of this question of food.

So when the American Red Cross formulated its peace time health program, nutrition work was given a prominent place, and in setting up plans for health centers there was included a plan to at least begin education in the importance of proper food in each community.

May I interject here the statement that the Red Cross does not aim to cover the health field? It mapped out its health program with due regard to the important agencies now operating there; namely, the doctor, the health officer, the educator, and the private health agency, and to the importance of fitting the activity to the organization.

The American Red Cross, at the close of the war consisted of some twenty million members grouped together into chapters and branches to the number of over fifteen thousand, and scattered over the entire United States. Every community had its Red Cross organization. Every community had developed a group of workers who had become interested in work other than their own special vocation. All had become interested in "the other fellow." All had found that there was time in which to do some of this volunteer work.

Much of this work related to the health of communities, so a definite interest in health work was created.

Needed Health Work

The great need in the health field seemed to be the education of people in personal hygiene, and in the importance of strengthening and properly using the health agencies now existing.

Enough knowledge of how to live existed in the minds of health experts to "increase the average length of life

fourteen years in one generation," if that knowledge was lived up to by people generally. To "get that knowledge across" and then to base health habits upon it was the next important health work.

The health center is an ideal facility for this kind of work and especially fitted to the American Red Cross because it is a community project, and the American Red Cross is in close touch with thousands of communities. Then, too, its millions of members are somewhat in tune with the health work, and want to continue it.

The health center, among other things, aims to keep the community in as close contact as possible with all national organizations which are promoting health. It does this by presenting in attractive form the publications of these organizations and devising social means of getting these publications in the hands of those who need them.

Many of these organizations, realizing the importance of proper food, have prepared, under the guidance of experts, some excellent pamphlets, these of course will be dispensed from the health center.

There is a more definite and more powerful contribution along this line that I believe the health center can make. There are in probably every community numbers of children who are undernourished, some on account of some debilitating disease or unhygienic habits, but many more because of improper food. I know that it is possible to bring this last group up to normal weight, better health, and more efficient living by properly feeding them.

Demonstration Good Method

Here is a dramatic method of bringing to a community the importance of proper food. I believe there are in most communities persons who can, under the direction of experts in our division offices, prepare this food and see that a selected group of undernourished children gets it, to the great advantage of the children themselves, and to the advantage of the community as a whole. Of course, there is a technic which must be followed if such a demonstration is to make a real contribution, but that technic is rather simple. It can easily be comprehended and followed by any intelligent woman. The Red Cross hopes through its health centers to interest some of its chapters in making demonstrations of the proper feeding of children.

You will understand, of course, that these demonstra-

*Read at the annual meeting of the American Dietetic Association, New York City, October 25-27, 1920.

tions are to the scientific nutritional clinics as set up in some of our larger cities, as are country doctors to our highly trained specialists; but, as the country doctors, they have their place. Wherever it is possible to install the more elaborate project, that is installed, but it certainly is not wise to wait until our rural chapters (80 per cent of the American Red Cross) can afford them, to do something along this line. Two great values will come from this work, namely, the excellent results as indicated by increased weight and greater vitality in the children themselves, and the education of the local people who conduct the experiment.

I believe it will prepare the way for more elaborate demonstrations along the same line, and eventually, bring

about the establishment of definite, continued, and trained oversight in this work.

I believe, too, that enough supervision can be exerted from our division headquarters to insure a proper technic and, in many instances, to enlist the aid and direction of local experts, such as home demonstration agent or domestic science teacher.

Under this plan thousands of communities may be stimulated to think and act more sanely in the matter of feeding not only children but adults, whereas, if we waited for the paid expert, it would mean that these thousands of communities would suffer for many years.

The Health Service Department of the American Red Cross seeks your cooperation in rendering this great service.

DIETETIC TREATMENT OF DISEASES OF METABOLISM AMONG OUT-PATIENT POOR*

BY MAX KAHN, M.A., M.D., PH.D., ATTENDING PHYSICIAN, DISEASES OF METABOLISM, AND DIRECTOR OF LABORATORIES, BETH ISRAEL HOSPITAL; ASSOCIATE IN BIOLOGICAL CHEMISTRY, COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY, NEW YORK CITY

THERE are a number of problems that present themselves in the care of the poor patients suffering from some disturbance in metabolism. They are chronic patients and they tax the endurance and generosity of the physician, the dietitian, and the social welfare worker. They are old people, or elderly people, usually, and the professional welfare worker feels rather disinclined to exert herself indefinitely for their sake. The question that I shall endeavor to discuss borders on the domains of social charity, dietetics, and medicine. I may, therefore, have to diverge from the caloric value of food and a well balanced diet in this paper.

There is a tendency on the part of the welfare worker to react with little interest in the case of a chronically ill, elderly patient. It is true that from an economic point of view it is poor business to invest money in the care of such sick. They never become productive members of society. They will, most likely, always remain a burden upon the charity organization. Why bother with them, when there are acutely ill patients, young and robust, who can be helped for a little while and who then become self-supporting? The injustice of such a tendency is great and self-apparent, and yet it is ever present.

These patients are derelicts on the road of misery and poverty. They are veterans of the battles of life who have lived industriously until age and disease have made them dependent upon our charity—so often wanting in us. To neglect them is to show a sense of utter lack of social responsibility. It is as if a people were to neglect crippled war veterans who have sacrificed their all for the safety of their countrymen. Such a condition of affairs is intolerable and should be remedied.

Should Be Special Budget for This Work

How can one treat an old diabetic patient, who not only has not the wherewithal to purchase the special food necessary, but has not the very bare means of subsistence? To what purpose is it to give advice as to diet and medication, when the patient does not know where to get his next meal? Suppose this patient is referred to

the social service department. After due investigation, he is helped for several weeks, and then the help stops, for there seems to be no end to the assistance to be extended.

I have proposed that a certain budget be assigned to the social welfare department to be used by the dietitian at her discretion. Then when such cases do appear in the clinic, the physician, the dietitian, and the social worker will not feel so helpless.

The dietetic treatment of the poor must be especially circumspect. It is my lot to attend to a clinic serving the very poorest of the poor. In advising a diet for them, the physician must have the following facts clearly before him: (1) The economic status of the patient. (2) The foods that can be most economically purchased. (3) Instruction of the patient by the dietitian in the preparation of foods. (4) Continued and repeated examination of the patient, his state of acidosis or sugar tolerance in diabetes; his degree of edema and nitrogen retention in nephritis, etc. (5) Investigation of the home life of the patient.

The economic and financial condition of the patient must be known. Those dependent on the support of their relatives must be urged to follow implicitly the directions given to them. It is advisable, occasionally, to speak to the relatives who are supporting the patient and impress them with the desirability of following the dietetic regulation, and with the health penalty that will follow disobedience. Amongst the poor, especially the Jewish poor, the family ties, and the family affections are very strong, and these words of caution will help very much.

Must Make Financial Arrangements

When the financial status of the patient is such that he or she must become a burden upon charity, we must see to it that organized welfare work accomplishes its duty. The arrangements must be made with "the butcher, the baker, and the candle stick maker," to have the necessary food ingredients supplied to the patient. One point must be remembered, and I was taught this by a social service worker, that more than the necessary provision must be given to the patient if she be a mother, for otherwise, the mother will share with her children and will

*Read at the annual meeting of the American Dietetic Association, New York City, Oct. 25-27, 1920.

herself abstain from the food in order to see that her children have enough.

If something suitable can be found for the patient to work at and help in earning his subsistence, well and good. If not, it is the duty of the state or of the welfare department to see to it that proper support be extended to the ailing individual.

The dietitian must see to it that in carrying out instructions of the metabolist so far as food ingredients goes, only such vegetables and other foods are recommended as are in season and can be obtained easily and cheaply. In this regard, the dietitian serves her main function. And not only this, she is to visit the home of the sick, or have classes in the hospital to which the sick can come and be shown how to cook the vegetables and other food properly and palatably.

Religious Factors Important

There are many religious factors in the preparation of a diet. I am especially able to discuss the diet question from the orthodox Jewish viewpoint. You know, for example, that Catholics refuse to eat meat during the Lent season. The Jews also have certain religious regulations in the foods that are allowed to them. The more miserable and poor a person is the more there is implanted in him all superstitious and religious observances. He seeks his consolation in the church, the synagogue, or in the various medical cults. At that time, one cannot teach the patient science or logic. One has to recognize these prejudices as one recognizes varying tastes, and cater to them. To ignore these scruples, or belittle them, is to work harm to the patient and arouse animosity toward the dietitian.

On a part, which I will quote, of Chapter XIV of Deuteronomy in the Old Testament, many of the dietetic laws are founded:

"Thou shalt not eat any abominable thing."

"These are the beasts which ye may eat: The ox, the sheep, and the goat."

"The hart, and the roebuck, and the fallow deer and the chamois, and the gazelle, and the wild ox, and the antelope."

"And every beast that hath parted hoofs, and whose feet are cleft into two claws, and cheweth the cud among the beasts—that alone may ye eat."

"Nevertheless, these shall ye not eat of those that chew the cud, and of those that possess the divided cloven hoof: The camel, and the hare, and the coney; for they chew the cud, but divide not the hoof; unclean are they unto you."

"And the swine, because it divideth the hoof, yet cheweth not the cud, it is unclean unto you; of their flesh shall ye not eat, and their dead carcasses shall ye not touch."

"This may ye eat of all that is in the waters: All that hath fins and scales may ye eat;"

"And whatsoever hath not fins and scales shall ye not eat; it is unclean unto you."

"Every clean bird may ye eat,"

"But these are they which ye shall not eat of them: The eagle, the ossifrage, and the osprey,"

"And the glede, and the kite, and the vulture after his kind,"

"And every raven after his kind,"

"And the ostrich, and the night-hawk, and the cuckoo, and the hawk after his kind,"

"The little owl, and the great owl, and the swan,"

"And the pelican, and the gier-eagle, and the cormorant,"

"And the stork, and the heron after his kind, and the lapwing, and the bat."

"And every winged insect is unclean unto you: it shall not be eaten."

"All clean fowls may ye eat."

"Ye shall not eat anything that dieth of itself; unto the stranger that is in thy gates canst thou give it, that he may eat it; or thou mayest sell it unto an alien; for

thou art a holy people unto the Lord thy God; thou shalt not seethe a kid in its mother's milk."

Upon the last injunction has been raised a whole system of dietetic ritual. You must remember that there are nearly four million Jews in America. In the centers where population is densest (in New York, Chicago, Pittsburgh, Boston, Philadelphia, Detroit, etc.) and where poverty holds its sway, these religious questions are very important. The rabbis have explained the injunction of not boiling the kid in its mother's milk, that meat and milk things must be kept separate. One cannot eat butter with meat nor with fowl. Nor can one use an implement that had touched milk or its products to serve in the eating of meat or its products.

There is a crying need for dietitians who understand the Jewish ritual. It is not essential that they be of the Jewish faith, as long as they are cognizant of the Jewish prejudices. This is especially the case with visiting dietitians and with those who are to become connected with orthodox Jewish hospitals, in contradistinction to the reformed Jewish hospitals.

In the advice given to diabetics, one must remember that while it is desirable to keep the patient sugar free, it is especially essential to keep his H ion concentration, his acidosis, normal. This can only be done by limiting the fat intake. For while the diabetic individual is characterized by a disturbance in the metabolism of carbohydrates, he is also, due to this fact, suffering from an improper breakdown of his body fats with the resulting formation of acetone substances, which are so toxic. The patients must be, therefore, cautioned against the indiscriminate use of fats.

DR. EMERSON APPOINTED MEDICAL ADVISOR OF BUREAU OF WAR RISK INSURANCE

Dr. Haven Emerson, formerly commissioner of health of New York City, has been appointed to the position of Medical Advisor and Assistant Director of the Bureau of War Risk Insurance. Dr. Emerson is well equipped to serve in this new capacity. For a number of years he was instructor and demonstrator in the departments of physiology and medicine at the College of Physicians and Surgeons of Columbia University, and assistant attending physician at Bellevue Hospital, at the same time practicing general medicine.

Dr. Emerson's contacts with the problems of preventive medicine and public health were established through his membership on the New York Health Committee, the Public Health Committee of New York Academy of Medicine, and in the New York Tuberculosis Association. In 1914 he was appointed sanitary superintendent and deputy commissioner of health of New York City, and from 1915 to 1917 he was commissioner of health.

During the war Dr. Emerson served with the American Expeditionary Force. In 1920 he organized the Department of Hygiene and Preventive Medicine at Cornell University, and directed the Hospital and Health Survey of Cleveland, Ohio, for the Cleveland Hospital Council. He returned recently from Europe, where he had been sent as a delegate from the National Tuberculosis Association to the International Conference on Tuberculosis.

The *Medical Press* calls attention to the importance of exercise in maintaining health. It also reminds us that, whereas in a state of nature the struggle for existence necessitated a great deal of activity, the struggle for existence in the civilized state tends to make man forget exercise to an alarming degree.

DEPARTMENT OF PUBLIC WELFARE RESUMES ITS WORK IN DIETETICS

BY M. SMITH, DEPARTMENT OF PUBLIC WELFARE, NEW YORK CITY

IN AN effort to amplify and extend the work of the dietetic bureau of the Department of Public Welfare of New York City, Commissioner Bird S. Coler has instituted a bureau of nutrition, and appointed as departmental dietitian, Miss Elva A. George. Hitherto the food bureau of the Department of Public Welfare covered the work of making institutional menus, food requisitions, census records, condemnation records, computations for food contracts, etc. It was administered by a clerk in charge and four assistant clerks. The dietitians in the hospitals were under the supervision of the superintendents of the hospitals and nurses' homes. While most of these were trained household economics women, in a number of instances attendant nurses and housekeepers were under salary as dietitians and were known as dietitians in the institutions. Only two were certified by the civil service commission.

Recreate Bureau of Nutrition

With the appointment of a departmental dietitian, the new administration departs somewhat from the older régime, in that there has been recreated a bureau of nutrition; as was originally designed. There have been eliminated certain features of its practices having no relation to its purpose, such as originating food requisitions, menus, condemnation records, contracts, calculations, etc. The commissioner has, under the administration of a departmental dietitian, added large responsibilities which properly belong within the scope of its duties.

There is no city in this country and probably none in the world that has so huge and unwieldy a group of public institutions under its wing as the New York City Department of Public Welfare. When it is appreciated that the department embraces ten great institutions, for the greater part of the time filled to capacity with the sick, the poor, and the unfortunate children of the metropolis, and that daily each of these populated hospitals and child caring institutions must be fed three times, something of the dimensions of the task may be approximated. And, in addition to the regular routine work of feeding the great institutions, with its many ramifications, there is the additional experimental and extensive program that is being gradually put into effect under the capable leadership of Miss George, with the cooperation and advice of Dr. John P. FitzGerald, medical superintendent. Always in the exercise of judgment on medical nutrition the bureau cooperates with Dr. FitzGerald's bureau and, in the promulgation of any advanced and untried methods, Commissioner Coler is brought into consultation. The local institutional dietitians are encouraged at all times to obtain the judgment of the physician immediately in charge of the patient, as to the dietetic requirements. It has been discovered that neither the wishes of the patient nor the discretion of the attendant nurse in the matter of a selection of diet is to be relied upon solely, and therefore the more scientific and experienced mandate of the attending physician in the case is requested.

The departmental dietitian's duties are manifold and her responsibilities commensurate with the immense amount of detail, general executive, inspectional, and educational work that is carried on under her direc-

tion. Fresh from a similar capacity with the American Red Cross stationed in Washington, D. C., Miss George brings to the department work, qualifications that will render the most intelligent and expert service to the Department of Public Welfare. In general, she supervises the character of dietary, the cooking and serving of foods, and the elimination of waste in all institutions of the department. It is also her task to determine that the varieties, quality, and amounts of foods purchased are in accordance with the specifications and the standard requirements. It is her task to inspect the care and storage of foodstuffs. It comes in her domain to pass upon kitchen plans and equipment. Lastly, under the title of general work, come the periodical consultations with superintendents of training schools on the course in dietetics for student nurses of the department.

Under the classification of executive duties, the department dietitian is in charge of the personnel of the bureau of nutrition and responsible to the commissioner, and must confer with the general medical superintendent on dietaries and personnel; also with the purchasing agent on food qualities, prices, and deliveries; with the auditor on condition of funds, and with the heads of institutions. Where it is necessary to revise requisitions and menus of the different institutions, this is done, as well as to keep informed on sources for obtaining dietitians, and kitchen and dining room help. When desirable, the departmental dietitian also calls meetings of institutional dietitians or confers with them when visiting the institutions.

Once a month it is the duty of the departmental dietitian to visit and inspect each of the ten institutions directly under her surveillance. In this tour of inspection she covers the dining rooms, kitchens, bakeries, and store-rooms of the department in order to keep informed of the quality, quantity, storage conditions, preparations, serving, and conservation of food supplies. The dietitian's survey of these rooms takes in also the sanitary conditions and the equipment in use, the condition of repair in which floors, walls, windows, equipment, etc., are kept. A report to the head of the institution or to the commissioner is the sequel of this mission.

Educational Work Also Her Province

A wholly different phase of work which is in the dietitian's province is that labeled "educational," which, though not engaging as much of her time as the other, is basically one of the most important functions of her position, for it is upon this educational work that the whole fabric of thorough and intelligent cooperation between the departmental dietitian and the dietitians in the various institutions is founded. By reason of her years of experience in the proper preparation, cooking, and serving of food, Miss George is able to pass on to the women immediately under her the knowledge she has acquired in this field of endeavor. Therefore, all dietitians and cooks of the department are instructed by Miss George in this art; thereby insuring the most efficacious and efficient service to the department. Institutional dietitians are trained in household economics before appointment, pupil dietitians are entered in institutions for a term of

practice, with a certificate of experience granted at the end of six months of satisfactory service.

Coincident with the recreation of the dietetic bureau there has been launched within the ranks of the department's dietetic personnel, a movement to modernize so far as possible standards and equipment for the various institutions. There have been proposed since July of 1920, labor-saving devices in kitchens and serving rooms; modern and increased equipment, mixing machines, dish-washers, steam counter, food conveyors, sanitary round tables for small groups of inmates and patients, etc. Also has gone into effect the originating of all menus and requisitions in institutions with check and record at the central office, and the standardization of cutting and distribution of meat in institution butcher shops.

Appoint Welfare Dietitian for Hospitals

Perhaps the most forward looking and human experiment now being tried out by the bureau has to do with the little institutional children, and the inmates of the homes for the aged and infirm. In the not far distant past the feeding of these folk was a routine job, it was merely a question of getting the food to the inmates, regardless of the manner in which it was served or received. Often, under this old system, the kitchen and dining room helpers did little to make the meal a pleasant occasion for the institutional charges. To many it was a mechanical task which had to be performed three times a day, and the inmates could take it or leave it, there was little sympathy expended. But, with the selection of a welfare dietitian for tuberculous and children's hospitals and for the homes of the aged and infirm, this situation has changed. It is now the duty of this especially appointed welfare worker to see that a proper sympathetic attitude exists between the patient and the members of the kitchen and dining room forces, on the cooking and serving of food. In a sense, the inmate becomes in fact an individual to be treated with as much sympathy and understanding as though he or she were not dependent on the city's charity. Also, it is the duty of the dietitian to provide intelligent and constructive criticism from the dining room to the administrative dietitian's office, with the end that the program in mind may be carried out effectively and without hitch.

Along with other innovations in the dietary department has come a movement to secure an increase in salary for the institutional dietitian, her value to the department being more fully appreciated than ever before. It is hoped that salaries for this position will be placed in the \$1,500 competitive class. Lastly, a modification of institution standard dietaries and the basic quantity food tables is under consideration by the city authorities.

It is becoming more and more important to place the dietary work of the city institutions in the hands of the trained dietitian and to recognize her very important function in the community.

TO REBUILD OLD HOSPITAL

The interesting announcement comes from Philadelphia that the managers of the Pennsylvania Hospital, which was founded in 1751, and which is the oldest voluntary hospital in the United States, are considering the question of rebuilding the institution, preserving, however, features of the present hospital which are of historic interest and value. Dr. S. S. Goldwater, of New York, has been engaged to act in an advisory capacity to the board of managers in this connection, and Dr. Daniel D. Test, superintendent of Pennsylvania Hospital, will be associated with him in the work.

NEWS ITEMS

Miss Elna Becker, formerly at the Pennsylvania Hotel, New York, is now with the Crane Candy Company of Cleveland.

Miss Mabel Dunham is director of a tea room and food shop which has been recently established by the Woman's Club, of Rockford, Ill.

Miss E. M. Geraghty was a patient at Presbyterian Hospital, Chicago, for several days, where she submitted to a minor operation.

On March 14, the Philadelphia League of Nursing Education invited the dietitians section to join them in a round table discussion on teaching dietetics.

Miss Hattie Brooks has finished the course in student dietitian training at Johns Hopkins Hospital, and has been given the appointment of assistant dietitian with Mrs. O'Dea.

Miss Bertha Hyde has been granted a leave of absence from Cincinnati General Hospital for six months because of ill health. Margaret Russell is carrying on the work of the department during Miss Hyde's absence.

Miss Mary Cunningham has given up the work at the Youngstown Hospital and accepted a position as dietitian at the Hanover Hospital, Milwaukee. Miss Lulu Winans, who has been at St. Luke's Hospital in Chicago, succeeds Miss Cunningham at Youngstown.

Miss Meta Reese has returned to the Methodist Hospital of Philadelphia, after several months' leave of absence. Miss Katherine Williams substituted for her during her absence. Miss Williams has accepted a position as dietitian of the Jewish Hospital in Philadelphia.

Miss Maude Perry has been critically ill for several weeks at the Montreal General Hospital. She will probably not be able to resume her duties as head dietitian at that hospital for some time. During her absence, her assistant, Mildred Haines, is in charge of the department.

Miss Ruth Bigelow, dietitian of the Abington Memorial Hospital, Abington, Pa., has resigned to take charge of the dietetic department of the Danville Hospital, Danville, Pa. Miss Ellen Horton, of the Delaware Hospital, Wilmington, Del., will replace Miss Bigelow at Abington Hospital.

The regular monthly meeting of the dietitians section of the Home Economics Association of Philadelphia was held February 24, at the Pennsylvania Hospital, Eighth and Spruce Streets. It was a "get acquainted" meeting. Tea was served, followed by a round table discussion of the dietitian's problems.

ALBANY MEDICAL COLLEGE HAS POST-GRADUATE COURSE

The Albany Medical College is carrying on a continuation of its postgraduate course in infectious diseases and public health for practicing physicians and public health officers. The course is given jointly by the College and the New York State Department of Health, and registration is limited to graduates. Informal conferences and practical demonstrations are given, with special consideration of the diagnosis and treatment of pneumonia and tuberculosis. The organization and work of industrial medical departments is also considered. Special work in venereal diseases is arranged for classes of two. The course extends from March 3 to June 17, one day a week.

Extensive additions are planned by the State of Illinois for the Alton State Hospital, at Alton. The estimated cost is \$500,000.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and
Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Superintendent
Mt. Sinai Hospital, Cleveland, Ohio

THE MARKET'S TREND

By CHARLES L. HAYS, CHICAGO, ILL.

IN CHICAGO, business recovery is slow, but is going ahead smoothly and with few outward signs of distress. In the face of continued tightness of money and curtailment of industrial activity, it is paradoxically true that retail business for the first three months of the year compared very favorably with the first quarter of 1920, even when reckoned in dollars, notwithstanding the reduction in prices. Road sales and mail orders of wholesalers are in excess of those at the corresponding time last year, but merchants are still buying in small quantities and frequently, avoiding distant commitments. The number of idle freight cars on the railroads has increased in the last month, and is now the highest ever recorded. Steel and iron production has been reduced to between 25 and 50 per cent of capacity, and in other lines of manufacture, except textiles, evidence of a revival of activity is lacking. Bank deposits are lower, principally because of the decrease in the prices of commodities, but loans hold up stubbornly. Money rates are unchanged, except for a slight shading of commercial, which is 7.5 to 8 per cent, against a minimum of 8 per cent a month ago.

Unemployment Increased

Unemployment has increased, and this is being reflected for the first time in a reduction of savings deposits, the trend being now definitely downward, after six years of steady and rapid increase. The loss so far is slight, and its chief significance is in marking the passing of the crest of the wave of accumulations of workers. The latest figures from the Federal employment service, giving reports from 1,423 firms usually employing 500 or more each, and located in sixty-five industrial centers of the country, show a decrease of 16,295 in the number employed on March 1 as compared with a month previous. The principal decreases are in these industries: iron and steel, railroad repair shops, chemicals and allied products, liquors and beverages, paper and printing, and food products.

Building conditions are not favorable to a revival of activity on a large scale, principally because of the labor situation. The unions are resisting efforts to bring about a modification of wage schedules, and unless these trades undergo a change of mind before the time for contract renewals on May 1, their attitude will continue to be, as it has been for the last year, the chief obstacle to a resumption of construction work in anything like the extent which the acute housing shortage demands. Steel prices have been reduced about 25 per cent, brick have been

cut from \$16.00 to \$12.00 a thousand, the first reduction in more than a year, and other materials are off moderately. Lumber dealers say their prices have been reduced 30 to 50 per cent from the peak, but architects assert that they are still nearly 100 per cent higher than before the war. A recent estimate of architects placed the reduction in all building costs from the highest point at 16.71 per cent, hardly enough to induce any marked activity.

Food Prices Lower

Food prices have worked steadily lower in the last month. Flour is about \$1.00 a barrel lower, butter three cents a pound, eggs eight to ten cents a dozen, and potatoes, at eighty-five cents, are off fifteen to twenty-five cents. Grains have reached the lowest price recorded in six years, but prepared cereals have not followed them to the full extent of the reduction. Sugar, after stiffening to eight and a quarter cents, wholesale, for fine granulated, is a half cent lower because of the financial troubles in Cuba. Meats are a little lower, but in the cities the decline has not been commensurate with the drop in the prices of livestock, and in some lines, notably cured products, the season of greatest demand for which is approaching, prices have even advanced. Canned goods and dried fruits, especially the lower and medium grades, are substantially lower, but the higher quality goods show little change. There are still considerable quantities of canned fruits from last year's pack being carried by owners who are reluctant to sell at the reduced prices, which may further depress values; but there has been a better clean-up of vegetables in anticipation of the new pack, in effecting which dealers have suffered material losses.

Drugs and chemicals have declined further, resale offerings acting as a weight on the market. In many cases manufacturers have been compelled to meet or approach the secondhand figures. Recently, however, there has been a little less of these goods and the markets have been more under the control of producers. Quinine has advanced somewhat among secondhands, and importers and concerns which a while ago were offering goods at sixty-two cents are now asking sixty-eight cents, which is only two cents under the price of domestic manufacturers. Rochelle salts have been reduced two cents to a new bulk price of twenty-seven cents. Seidlitz mixture has been marked down one and a half cents a pound to a range of twenty-one and one-half to twenty-two and one-half cents. Ether is in steady demand, recent reductions in price being due more to cheaper cost of raw materials

than to conditions in the ether market. Grain alcohol is plentiful at \$4.80 in five-drum lots. Removal of much cheap formaldehyd from the market has hardened the price to sixteen cents. Hypophosphites are off ten cents a pound on the calcium to seventy cents, and twenty-five cents on the potassium to \$1.10. Permanganate of potash is slightly lower at fifty to sixty-two cents.

Furniture Still Remains High

Furniture is still a laggard in the readjustment process and the movement of this kind of merchandise is slow in consequence. Lower steel prices have made possible some modification of quotations on articles in which metal is used, such as beds. The demand for crockery and glassware held up well until the last month or so, which prevented any noteworthy revision of prices, but there are indications of the approach of conditions more favorable to buyers. The department of household furnishings in which there has been the greatest change is that of bedding. Cotton and wool are very low, as compared with recent price levels, and the decline has been followed probably more closely by sheetings, pillow-cases, blankets, and similar staples than by any other class of merchandise.

Demand for paints and varnishes has been strengthened recently by a resumption of operations in many automobile plants, and prices are firmer. The effect of this change is not yet noticeable in the linseed oil market, but it probably will be soon. Oil at sixty cents for raw and sixty-two cents for boiled, warehouse delivery, is seven to nine cents lower than a month ago, due to the weakness in the flaxseed market in the last month.

The change for the better in the automobile industry is one of the most encouraging features of the industrial situation, and, together with a brilliant prospect for large yields of soil crops this year, has done much to offset the discouraging influence of financial stringency, lessened mine and manufacturing activity, shrinking railroad traffic and labor troubles. Winter grains came through the cold season in good shape, and weather conditions this spring have been very favorable for growing plants and for the seeding of a large new acreage.

Coal Prices Show Some Reduction

Coal prices have been reduced fifty cents a ton this month, but the placing of contracts for steam grades and domestic fuel is so slow that leaders in the industry are predicting another squeeze in the late summer or fall, when belated buyers will all be in the market at once. Because of lack of demand, mine production has been reduced to 30 or 40 per cent of normal. Purchasers are deterred by the fact that prices to consumers are very little lower than last year, notwithstanding the reductions at the mines, and distributive costs are just as high. It is not easy to see any likelihood of a change in the situation favorable to buyers, but it is easy to imagine one that may be worse.

Crude rubber prices are about where they were a month ago, at sixteen to nineteen cents, in spite of the improvement in the automobile industry. The trouble with most of the tire companies was that they were carrying heavy rubber inventories, and most of them have much liquidation to do before their needs will affect primary markets.

STANDARDIZATION OF FRUITS AND VEGETABLES FOR A \$200,000,000 BUSINESS

BY ROBERT BIER, INVESTIGATOR IN GRADES AND STANDARDS, BUREAU OF MARKETS, U. S. DEPARTMENT OF AGRICULTURE

HOSPITALS are now buying foodstuffs at the rate of two hundred million dollars annually. A small saving on a business of this magnitude would constitute a tidy sum in itself, and no sound business principle should be neglected in placing the purchasing department upon an economical basis. Progressive business concerns recognize this fact and now buy large quantities of their raw materials upon standard specifications. This practice also should be followed by hospital buyers in the purchase of fresh fruits and vegetables.

The agricultural interests have been slow to adopt standards for marketing their crops. Probably their isolation and individuality have been important factors in preventing such adoption. However, modern means of transportation and communication are bringing farmers closer together, with the result that there has been a marked increase in the number of farmers' cooper-

ative organizations. Associations, especially those handling fruits and vegetables, find that one of their first problems is the formulating of some standard for their products on which they may conduct business. Again

the rapid increase in urban population has brought into cultivation lands far removed from the primary markets. Shipments from these sections, if poorly graded, generally return very little to the grower when he has paid the freight, commission, package, and growing charges. These conditions are making it more and more essential that generally accepted standards be adopted which will minimize the large amount of waste now attendant upon shipment of ungraded crops.

The Bureau of Markets recognizing the advantages

and economies arising from the use of standards for fruits and vegetables, has been conducting studies in all the producing sections as well as in the large receiving mar-



Potatoes should be purchased on U. S. grades. The hamper at the left contains No. 2's, the other contains No. 1's.

kets, with the object of formulating such measures. Investigations have led to the recommendation of standards for white potatoes, sweet potatoes, northern grown onions and Bermuda onions, while preliminary studies have been made upon many other crops.

The advantage arising from the use of standards in the reduction of waste, and conservation of transporta-



Federal inspectors are stationed in twenty-five central markets. They will certify the quality and condition of your purchase at your request.

tion facilities, was recognized by the United States Food Administration during the war emergency. At this time the Food Administration issued a rule requiring that the United States potato grades be used by licensed dealers. When the regulation was canceled December 10, 1918, the results had been so satisfactory that the grades were continued voluntarily. However, this does not mean that all potatoes that are handled today are graded. In a study made by the inspection service of the Bureau of Markets, of 385 cars of potatoes shipped from New Jersey the past summer, it was found that 206 were below grade specifications for a No. 1 because of the presence of from 6 to 25 per cent of defective stock. Most of these defects were scab and second growth, both of which cause considerable waste in preparation for the table.

A hospital, in purchasing such supplies as chemicals or bandages, buys upon definite specifications. If bandages are bought, the quality as well as the dimensions are given, while in case of chemicals the purity of the product is specified. Fruits and vegetables may also be bought upon the basis of definite standards. A United States No. 1 grade requires that potatoes shall be sound, reasonably clean, and practically free from defects such as scab, rot or second growth. The diameter of round potatoes shall not be less than one and seven-eighths inches, while those which are long must be at least one and three-fourths inches. The grade thus gives the buyer about as definite specifications as are applied to the purchase of other supplies.

The hospital buyer will very often find that the market in which he buys foodstuffs does not recognize grades, but this fact should not prevent him from using grades in obtaining his supplies of fruits and vegetables. Such a

large organization as the United States Navy buys all these products upon the basis of definite specifications. Furthermore, through inspectors appointed by the Bureau of Markets, the Navy sees to it that such products meet the requirements stated in bids. During the period from September 1, 1919, to June 30, 1920, the Navy, at New York, accepted 8,337,493 pounds and rejected 273,263 pounds, and, in addition, cut 203,493 pounds from the weight because stock was improperly trimmed or in bad condition. If the hospital buyers should apply the same system in making their purchase of foodstuffs, and if the percentage of economy attained was as large, it would mean a saving of ten million dollars annually.

Buyers may raise the objection that they do not have sufficient technical knowledge of the fruits and vegetables they are buying, to apply grades in their purchases. This difficulty may be obviated by calling upon the inspection service of the Bureau of Markets. This service has offices in the twenty-five leading cities of the United States, besides authority to make inspection in 155 others. The inspection, however, is limited to that produce which has passed in interstate trade, and a charge of \$4.00 is made if a car lot is involved and \$2.50 if the lot is less than a car. These inspectors will advise hospital buyers without charge upon the use of standards or grades of fruits and vegetables in making their purchases. A list of inspection offices operated by the Bureau of Markets may be obtained by applying to the Bureau of Markets, United States Department of Agriculture, at Washington, D. C.

Buying foodstuffs upon the basis of grades as outlined, is the most economical method of making purchases. Copies of these grades may also be obtained from the Bureau of Markets. A business as large and important as that of the hospitals of the United States should be



Buy on the U. S. grades and protect yourself from excessive shrinkage.

just as alive to the needs of more economical methods in its management as any other modern business, and any measure which will add to the efficiency in operation should merit adoption.

The Odd Fellows of Bellevue, Pa., are having plans drawn for a \$250,000 home.

SECTIONAL LABORATORY FURNITURE

BY OSCAR T. SCHULTZ, M.D., DIRECTOR, NELSON MORRIS MEMORIAL INSTITUTE FOR MEDICAL RESEARCH OF THE MICHAEL REESE HOSPITAL, CHICAGO

IN THE remodeling of old laboratories and the planning of new ones, the furniture to be installed is one of the items of greatest expense and constitutes a difficult problem for the laboratory worker. Work tables and other pieces must fit the space available; they must give

and wiring. The matter of designing a number of pieces of laboratory furniture which would be more suitable to the medical laboratory, whether the



Fig. 1. Standard Section.

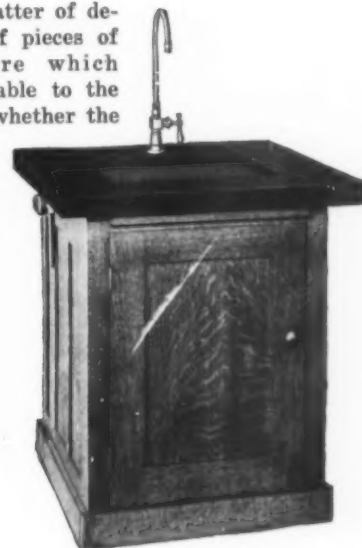


Fig. 3. Sink Section.

adequate room to the individual worker and should be so constructed as to afford him the greatest possible degree of convenience and comfort in his work; they should be well made and present a good appearance. In a new laboratory these requirements can be met by having the furniture especially designed to fit the laboratory and to meet the needs of the work to be done. The cost of such specially constructed furniture is very high and adds greatly to the expense of equipping a laboratory. With a limited budget, one is often forced to save on furniture in order to buy apparatus; the result is an installation which is unsatisfactory from the beginning and which becomes more so as time passes.

There are on the market standard pieces of laboratory furniture which are satisfactory for the chemical or biological laboratory. They do not, however, meet the needs of the medical laboratory, more particularly the hospital laboratory, in which different kinds of work must be done. The pieces on the market have been designed primarily for the student laboratory, they are too large for the smaller ones and each piece requires its own plumbing

work had to do with teaching, research or diagnosis, and which would be so constructed as to make use of the unit or sectional feature, was submitted to the writer. The laboratories of the Nelson Morris Institute, of which Richard E. Schmidt, Garden and Martin were the architects, are equipped with furniture which meets in an ideal



Fig. 2. Student Section.



Fig. 4. Chemical Section.

manner the needs of the individual worker. It seemed possible to modify this somewhat, in order that it would be satisfactory also for the student and general laboratory. From such tables, as in actual and continuous use

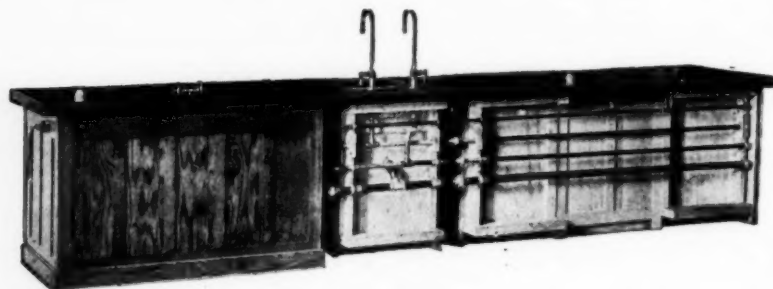


Fig. 5. Back view of Standard Section, Sink Section and Student Section connected together, with two back panels removed.

have been found to be satisfactory, the pieces illustrated have been adapted to meet the requirements outlined. The feature which permits the combination of several pieces either of the same or different type has been developed by the manufacturer.

In Figure 1 is illustrated a table for the individual



Fig. 7. Front view of Standard Section, Sink Section and Student Section connected together, showing removable panels in place.

worker. The top is seventy-two by twenty-eight inches, giving a working space of fourteen square feet, and is thirty-one inches from the floor. There is ample drawer and locker space; a desk slide on each side has been found of great convenience. As illustrated, this table is equipped with gas, electricity, and illuminator for microscopic work. A similar section for student use, decreased in size by omitting the drawer pedestal, is shown in Fig-

ure 2. This has a working space of a little over ten square feet. It also is supplied with gas, electricity, and illuminator. Any number of such units may be combined, the union being made by means of a narrow panel.

Although neither of these tables has water, each carries the piping for water and drainage, so that a sink section (Figure 3) may be combined at any desired place. A somewhat higher section (Figure 4) for chemical work can be combined with any of the units illustrated; in order that this chemical section may have its greatest usefulness, it will probably always have to be combined with a sink section. The method of combining the sections is shown in Figures 5 and 6; Figure 7 shows the appearance of a combination of the units illustrated in Figures 1, 2, and 3. Water, drainage, gas and electricity each requires only a single connection for an entire series

of combined units. Figure 4, as illustrated, has the sanitary base; this, as well as the other sections, can be made with either the solid or the sanitary base.

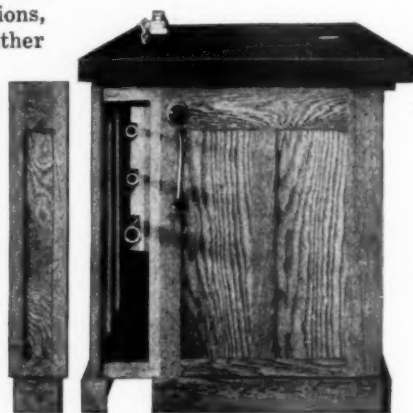


Fig. 6. Side view of Standard Section, showing removable panel, exposing pipes.

It is possible to apply the sectional principle to other types of units which might be combined with those illustrated. The latter, however, appear to have the widest range of usefulness and will meet most of the requirements of the medical laboratory. If remodeling, by any chance, becomes necessary at some later time, changing the units to fit the new conditions is an exceedingly simple matter.

REDUCING INSTITUTIONAL FOOD COSTS*

BY MARGARET HOOKER, DOMESTIC SCIENCE INSTRUCTOR, STATE SCHOOL FOR GIRLS, ADRIAN, MICH.

ALL meats should be selected with the same care as beef. Advantage should be taken of the laws our government makes to protect its people from inferior meats. Pork, perhaps, is not so profitable to buy in the carcass as beef; however, there are advantages either way.

Hog raisers used to raise two types of animal, "lard hogs," heavy weight, and "bacon hogs," light weight. But now they find it more profitable to produce a medium weight hog.

In purchasing a hog, its live weight should be about 250 pounds; when dressed, 190 pounds. The skin of pork

should be white and clear, the flesh a good pinkish color. Pork must be kept in a very cold place, around thirty degrees Fahrenheit, for fresh cuts. Oftentimes the fresh cuts are preserved by smoking or salting, these are the hams, salt pork, and bacon, principally. The preservative used in these meats does not make it essential to keep in a very cold place. However, a cool, dry room is the best place for them to hang, thus preventing the growth of molds.

If an experienced person is in charge of the butchering, the purchase of the whole carcass is economical. There are so many by-products which may be used to good advantage. Hogs are dressed without the removal of the head, all parts of this may be used, as the snout, ears, lips, cheek meat, and always, lard. "Leaf lard" is

*This is the second of a series of articles by Miss Hooker, on "Reducing Institutional Food Costs." The first article appeared in the April issue of THE MODERN HOSPITAL.

obtained from the fat in the abdominal cavity. This is the finest grade, it is very hard, and has the highest melting point of any lard. Other grades of lard are rendered from trimmings and fat which cannot otherwise be utilized. If there are facilities for smoking and salting hams and bacon, so much the better, but if the institution is large enough, the fresh meat can very easily be used.

Perhaps less labor is involved in the purchase of pork cuts. In buying a whole ham, the butt can be baked, the center, sliced to be fried or broiled, the shank boiled, and the rinds used for various purposes for which fat is needed. The meat for roasts is taken from the ham, the loin, and the shoulder. The loin roasts are thought to be the most desirable, but the shoulder roasts are cheapest. The best grade of breakfast bacon is obtained from the belly. A fairly good grade is taken from the jowl, this is best used for flavoring purposes. Bacon should be sliced so thin that it is nearly transparent, and if properly cooked, will lose 60 per cent of its weight. Bacon drippings make an excellent cooking fat. "Picnic ham" is a part of the shoulder meat, it is not so palatable as the other but very much cheaper. It is best used when the meat is chopped for casserole dishes or "minced ham." The two grades of pork chops are the loin and shoulder chops. The loin is considered the most desirable.

Pork is very rich meat and should be eaten sparingly even by persons in the best of health, and never under any circumstances should it be served to a sick person. Sometimes in the period of convalescence bacon is very good and acts as a stimulant to the appetite. The fuel value of pork is very high.

Lamb and Mutton

Mutton and lamb may be purchased much the same as beef, but the cuts are very different. One side of mutton consists of only six different cuts. Young lamb, often called "spring lamb," is considered very choice, while mutton is more nutritious, as it is the flesh of the mature animal. If a lamb has been well fed and cared for, it is still a "lamb" at the age of a year to eighteen months.

Mutton should be of a good red color and fine grained, the fat hard and flaky. Lamb can be distinguished from mutton by the reddish color of the bones, while those of

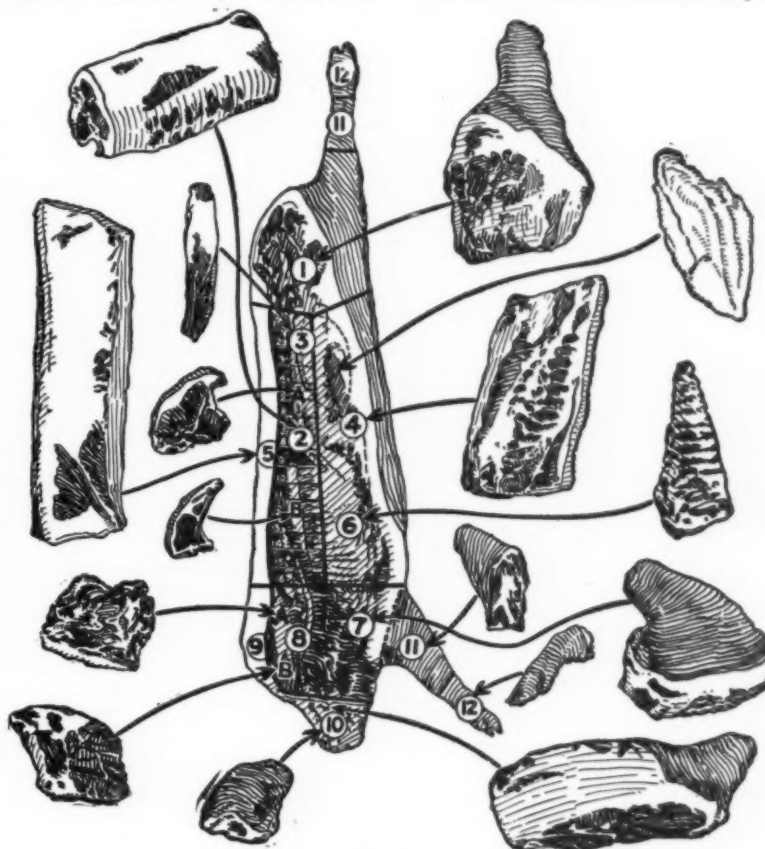
mutton are white. As mutton absorbs odors very readily, care should be taken to keep it in a cool place, away from anything with an offensive odor.

The fore quarter of mutton is cheaper than the hind, there is a larger amount of bone and the flesh is coarse and tough, but has a much better flavor. This is probably the reason for its popularity in mutton stews. In the process of cooking mutton stew, much fat comes to the top. This may be skimmed off and kept for other cooking purposes. To use this mutton fat it is best to combine it with some softer fat, as oleo or vegetable oils. Some persons object to the flavor of mutton fat, if it is to be used in cake making, the flavor may be disguised by the use of spices, chocolate, or any cake flavoring. This fat is most satisfactorily used in hot breads, as

biscuits or muffins, which are to be eaten the same day on which they are baked.

Lamb chops and fresh green peas are often replaced by mutton chops and canned peas, which is, of course, by no means a good substitute.

Chops are taken either from the ribs, loin, chuck, or shoulder. The rib chops are very choice, but contain little meat, the loin chops are perhaps the most profitable to buy. The leg or loin of mutton or lamb is best utilized by roasting, although sometimes it is boiled. Other roasting meat is obtained from the ribs, breast, and chuck. For stew meat, and soup, it is most economical to buy the neck and shank.



PORK CUTS

- ① FRESH HAM
Also used for smoked ham
- ② FULL LOIN (Center cut Mutton)
- ③ TENDERLOIN

- ④ BELLY
Made into bacon. The heart of this cut is used for the best grade.
- ⑤ LARD
- ⑥ FAT BACK

- ⑦ SPARERIBS
- ⑧ & ⑨ PICNIC
- ⑩ A REGULAR BUTT
- B BONELESS BUTT

- ⑦ & ⑧ PORK SHOULDER
- ⑩ CLEAR FLAT
- ⑪ JOWL
- ⑫ HOCKS
- ⑬ FEET

Courtesy Wilson & Co.

Fish

The fishing industry is becoming greater every year, due to the work of the United States Bureau of Fish-

eries. Many kinds of both salt and fresh water fish are being utilized which heretofore were neglected. With the improvement of facilities for packing and shipping fish, it is possible to purchase fish in good condition in nearly any community. Fish is at its best, naturally, when cooked almost immediately after it has been caught. Up to the time of selling it should be kept on ice or in a frozen condition.

In selecting fish, the one main point to be considered is the freshness. If it is fresh, the flesh should be firm, the eyes bright and bulging, the gills red and free from any foreign substance, and when placed in water the fish should sink.

Fish are divided into two general classes: (a) Lean or white fish, in which the flesh contains little oil, the

fat being concentrated in the liver, to this class belong cod, haddock, trout, white fish, lake pike, perch; (b) oily or dark fish, in which the fat is distributed throughout the flesh, to this class belong salmon, mackerel, herring.

Careful preparation of fish is very important. A fish should be cleaned and drawn immediately after it has been caught, then kept on ice or in a frozen condition until ready for use. Contact with other foods should be avoided on account of its odor. If the fish has been frozen, it may be thawed by placing it in cold water with skin side up. In preparation for cooking, it should be scaled, skinned or boned, sometimes all these processes being necessary.

If the fish is to be baked, the head and tail may be left on, but the eyes should be removed. Fish may be broiled, baked, boiled, steamed, or sautéed. Haddock and lake pike are examples of fish which are good bakers. The fish should weigh at least four pounds and should be stuffed with highly seasoned ingredients. White fish is best broiled or sautéed with one of the many delicious fish sauces.

Fish is a very good source of animal food. It furnishes a good change in the diet and digests about the same as meat. It is high in protein and fat, the latter applies to class (b), but low in extractives. Most persons tire of fish quickly, chiefly on this account. The idea that fish is a brain food is false. It is a good source of phosphorous, which is a necessary body constituent. Whether the institution is religiously influenced or not, try to establish "fish days" and utilize low priced fish, it can be cooked just as well as the higher priced without the marked difference that there is in meats.

Oysters

Among shellfish, oysters are the most important. They are in season from September until May. They are not harmful during the other months, but are flabby, and the flavor is inferior. Oysters are not economical for the average institution to buy; they do contain all six foods, but the bulk necessary in order to get sufficient food value would not balance either with the rest of the diet or funds.

Poultry

The subject of poultry is very broad. We will only consider here chickens, which are the most common. Chickens are divided into three classes: broilers, roasting

chickens, and fowls. Poultry is not protected by the United States meat inspection law, so the buyer should exercise great care in selection.

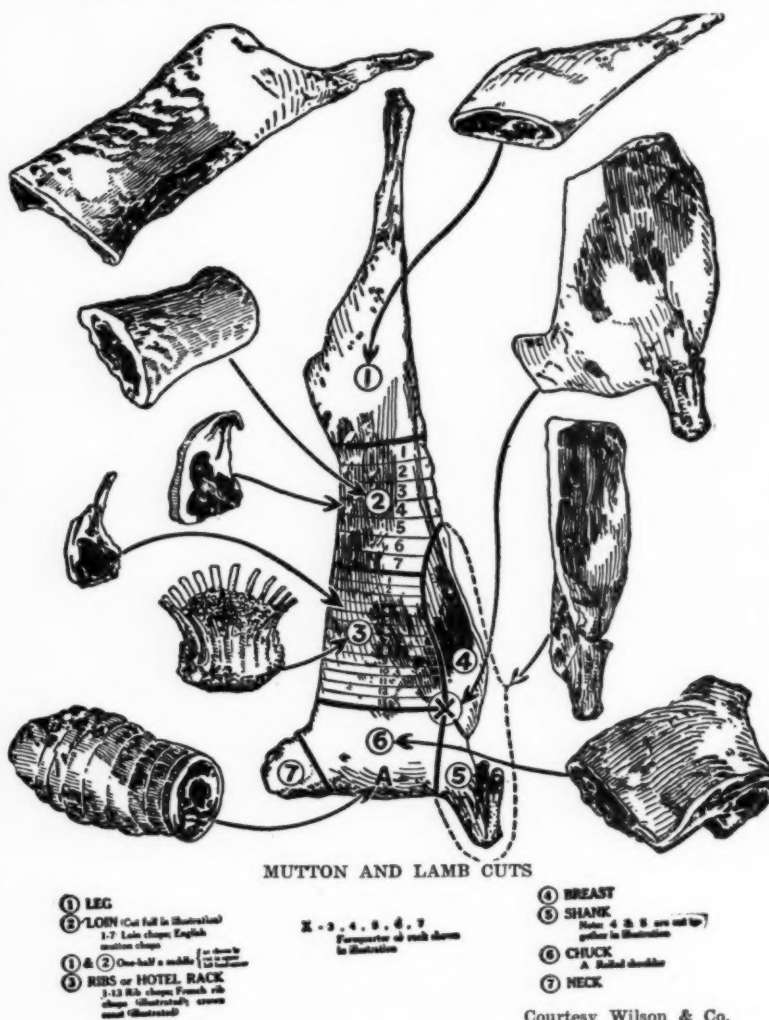
The same rules for selection should be observed in all three classes of chickens. See that the flesh is firm and that there is some fat underneath the skin, which should be of good yellow color. The odor should be good.

The majority of poultry which is on the market has been in cold storage, and to have kept properly it must have been in a frozen state. The popular demand seems to be for poultry not frozen, so it is not in that form when offered for sale. If possible, buy it in a frozen state, then there is no chance of previous deterioration.

Broilers are young chickens, usually ten to fifteen weeks old, and weigh from one and one-half to two and one-half pounds. These are quite expensive and a poor investment for the average institution. Roasting chickens include cockerels, pullets, and capons. These chickens are from eight to ten months old and weigh from four to six pounds. Capons may be distinguished from others because neck, wing, and thigh feathers still remain. In choosing these two classes see that they are plump, have soft, smooth legs and feet, flexible breast bone, pinfeathers, and tender skins.

Fowls are old birds. They are found on the market any time of the year at a nominal price. Fowls have hard and scaly feet, and a rigid breast bone, long hairs, rather thick, tough skin, and usually contain quite a little fat, which surrounds the intestines.

Cleaning chickens is an unpleasant task. Sometimes this is done at the butcher



shop, but it would be an extravagance for an institution to demand this service. The chickens of the first class are broiled or sautéed. Roasters are stuffed, and roasted or baked, as their name implies. The fowls, which no doubt are the most common because of their price, may be prepared in many delicious ways. Some of the best are chicken fricassee, Maryland, pie, gumbo, casserole dishes, à la king, and the favorite chicken salad. It is needless to say that the fowls are best in the long run, but broilers are the most choice.

Chicken is very easily digested, especially the white meat. This contains less fat, and is found on the breast and wing. The dark meat on the leg is more tough and is closely held together by connective tissue.

OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by HERBERT J. HALL, M.D., President, National Society for the Promotion of Occupational Therapy, Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

TO THE HOSPITAL SUPERINTENDENT

The editors of this section appreciate their opportunity for real service to occupational therapy. The magazine as a whole contains just the general information that any broad minded hospital worker should possess, and our section can always be useful as a means of communication among ourselves. But THE MODERN HOSPITAL offers us a still greater advantage. Each issue goes where we want good, reliable occupational therapy news to go, right into the office of the hospital superintendent.

We believe that prescribed occupation as a reconstructive measure is an essential hospital function. We want the hospital authorities to realize that we are not exploiting a fad, that we are not the frenzied purveyors of a nostrum, but that we are earnestly and conservatively trying to demonstrate and to standardize a system which will increase the efficiency of the hospital in its mission of reconstruction. We want, incidentally, to call attention to the fact that hospital occupational therapy need not represent a large increase in running expenses, but that unique among therapeutic measures, this new system may be made partly self-supporting through the legitimate sale of manufactured articles.

Already some of the hospital executives have become members of our national society. More should follow. Such endorsements of our ends and aims are of the utmost value. If the hospitals need our cooperation, we need the advice and sympathy of the superintendents and their assistants, the backing of the staffs and trustees.

The editors hope that this section will be read from month to month by the hospital administrators, and that they will not hesitate to write us, giving their advice and criticism, and their constructive suggestions.—EDITORS.

SIMPLIFYING THE RECORDS

There is no form of treatment more likely to be overestimated or undervalued than occupational therapy. We are as sure as we can be of anything, that careful occupational therapy shortens many a convalescence and brings the patient to his discharge in better shape for further progression than he would have been without the reconstructive work, but we must be very cautious in making our claims. Occupational therapy is only one of the many elements involved in treatment. The Christian Scientists attribute cure to their stimulating and absorbing belief—they do not allow for good nursing and the natural tendency of the diseased body to return to health. The patient who has consulted many doctors usually praises only the last one, the man who was called in just as recovery was about to take place. In our enthusiasm for occupational therapy we must not fall into any such errors.

That way lies discredit for any system. Conservatism in our claims will win for us the respect and confidence of those who are watching our work. It would be well, perhaps for a long time, to make no claims at all.

After a while our records will speak for themselves, but these records, if they are to be of value, must be well kept and easily comprehensible, especially to the medical mind. Generally speaking, the more elaborate the record system, the less likely it is to be well and faithfully kept. The system of many blanks and duplicates will defeat its own ends. The chances are that no one will take the trouble to read such reports after they are made, and the labor reacts badly upon the aide, who knows it is unnecessary and who needs her time and strength for other things. The whole record system should be studied carefully and reduced to the simplest possible terms.

The practice of occupational therapy is based upon the belief that a convalescent patient who is busy and interested will make more rapid progress toward health than one who is idle, discontented, and discouraged. We have observed that work with the hands brings about desirable states of mind, and that in certain appropriate cases mechanical and functional improvements are quickly brought about. We cannot record a state of mind except very generally and imperfectly. Measurements of motion in injured and stiffened joints are possible, to be sure, but even here we may not say surely that occupational therapy was alone responsible for the gain. The one thing we can record accurately is the time during which the patient has applied himself to a given job without serious fatigue.

However such a record may be interpreted in relation to recovery, it is well to know and to state clearly that a patient has or has not been able to increase the time of his work. Many subtle elements are involved, some we will never understand and most we do not need to understand. The self-evident fact is that John Smith,

SEA VIEW HOSPITAL OCCUPATION THERAPY

Month.....	Patient's Name.....	Ward.....
		Total No. Hours.....
TIME		
HOUR		
12		
11		
10		
9		
8		
7		
6		
5		
4		
3		
2		
1		
DATE		
	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	

who would otherwise have lain idle, whose convalescence would have been enlivened by nothing more exciting or useful than gambling or gossip, whose principal occupation would have been grumbling, has been able to apply himself without fatigue to a complicated bit of constructive work, at first for ten minutes a day, and then by gradual progressions for three or four hours. What has happened? We do not know, and literally we cannot tell. The medical record will say that the man is discharged well or much improved, and it will state what forms of treatment were used. We shall perhaps be required to make an estimate of the patient's functional improvement, of his ability to concentrate, and to sustain effort. But for the present we may be well satisfied to record what he has actually accomplished in the way of diversional or curative work during convalescence. Such an extreme reduction of detail may prove to be unwise. There will be chronic cases in which occupational therapy is the sole method of treatment. Here we may be more explicit, more elaborate in our record. But on the whole we should be aiming always for simplicity in our statements, and it should be our constant care to avoid unfair or extravagant claims.

Miss Dorothy Ross Carmer, head aide at Sea View Hospital, West New Brighton, Staten Island, N. Y., has devised an excellent chart, one which may be kept at the bedside or in the chart room and which may later be clipped onto the medical record. It could be improved by reversing the figures at the side so that the record line would read upward instead of downward.

Suppose the character of the work is changed midway in

the month and a substitution made of something much more difficult, something requiring more concentration or more physical effort, there would occur presumably a sharp decline or rise in the line, that might be confusing and deceptive. At this point we should write in the explanation. The progression would then be on a different level but would have the same relative value. Suppose the daily hours of work remain the same week after week. This might be interpreted to mean that the patient could not or would not do more. An explanatory note should be made on the back of the card or between the lines. The reason for an unvarying level may be that no more time is available or that the limit is made arbitrarily by the teacher because she fears that a longer time of work would bring about fatigue and discouragement. Quality of work is important, and there should be at least a monthly note on this point. Quite often improvement in quality will be as significant as increase in time. Let these simple notes be made and the occupational therapy record is complete, a record easy to write, easy to read, and to interpret.

There are many systems in use, some may be better than this. Occupational therapy workers everywhere are urged to send in their record forms to the editor. We will gladly publish any that may possess special features of interest. It is only by comparisons that we may hope to make rapid progress toward standardization that will unify and advance our work.

We need also a standard system for the stock and supplies, a simplified bookkeeping that will save work and still be accurate and complete.—EDITORS.

THE CLINICAL ASSISTANT

BY FRANCES E. WOOD, DEVEREUX MANSION, MARBLEHEAD, MASS.

I HAVE been asked to tell about a comparatively new position in occupational therapy which has grown out of the special conditions existing at Devereux Mansion during the last year. Practically all the patients at this institution do manual work in the shop. There is very little bedside work. We have three departments, cement, pottery, toy making, and hand weaving. Each has its own instructors and assistants.

The first consideration in this shop is the welfare and progression of the patient; the second, the training of apprentices; and third, the production of crafts work. In order to maintain a high standard in each of these departments it is necessary for the teachers to give practically all their time to the technic of the work and to the actual instruction of patients and apprentices. We have sometimes found it difficult to combine with these requirements enough personal attention to the patients. Here and there in the zeal for good work and for quantity production, patients have been allowed to overdo, and occasionally, because of some real or fancied disability, they have not been pushed ahead as fast as was consistent with their actual possibilities.

The need of what might be called a fine adjustment between the patient and teacher is met, to a considerable extent, by the oversight of the doctors, but just as the teachers are sometimes overtaxed with the technical requirements of their work, so the doctors are at times unable to give sufficiently close attention to the patient during actual working hours. This gap into which a patient occasionally falls, with unfortunate results, we

have been trying to bridge by the new position which I have held during the past year. The position might well be called that of clinical assistant in occupational therapy.

Supervises Work of Patients

It has been my duty to supervise the work of the shop, not at all from the technical point of view, but wholly in the interest of the patient. Although I do, at times, visit patients in their rooms before they are able to go to the shop, taking them work and supervising its execution, my time is mostly spent in the shop itself, watching the reaction of the patients to their work, straightening out such misunderstandings as may arise in their minds as to the significance of the work, keeping records of time and quality of individual work, looking for signs of fatigue or of overzeal, encouraging the slow and the timid. It has been my duty to report daily to the doctors any evidence that I could see of ineffectiveness in the application of the occupations to individuals. I have been asked to judge when it might be wise for the patient to change his occupation or to diminish or increase the time of work. At first thought it would seem that the regular teachers in the shop should be able to meet all these requirements, and for the most part they do. It is not intended that they shall resign their responsibilities as clinical instructors, but here, as in any large shop, the actual technical requirements are so considerable that it is a measurable relief to the teachers to be able to turn over special problems to the clinical assistant. The teacher, for instance, is obliged to move more or less

DEVEREAUX MANSION OCCUPATIONAL CHART.																																			
Patients' Names.	Each Space Represents a Quarter of an Hour.																								Kinds of Work.										
	AM.												PM.																						
	9:00	9:15	9:30	9:45	10:00	10:15	10:30	10:45	11:00	11:15	11:30	11:45	12:00	12:15	12:30	12:45	1:00	1:15	1:30	1:45	2:00	2:15	2:30	2:45	3:00	3:15	3:30	3:45	4:00	4:15	4:30	4:45	5:00		
Miss A.				X	X		X		O	X													X	O										Cement.	
Mrs. B.											O											X	O	O										Cement and Weaving.	
Mr. X.				X	X		O	X	X	O											X	X	X	O										Toy Making.	
Mrs. R.									X													X	X	X	O									Toys and Baskets.	
Mr. D.				X	X	X															X	X	X	O										Cement.	
Mrs. H.								O													X	X	X	O										Toys.	
Mr. F.			X	X																	X	X	X	O										Toys and Weaving.	
Miss O.			X	X	X		X														X	X	X	X	O	O	O							Weaving.	
Miss S.			X	X					O	O	O										X	X	X	X	O	O	O								Weaving.
Mr. W.		X	X	X		X	X	X	X	O	O	O									X	X	X	X	O	X	X	O	O	O	O				Weaving.
<div>X = Green headed tacks, the first prescription. O = Brown headed tacks, time added. Chart made of stiff cardboard or mounted on wood.</div>																																			

X = Green headed tacks, the first prescription.

O = Brown headed tacks, time added.

Chart made of stiff cardboard or mounted on wood.

rapidly from one patient to another. Patients who are beginners, or who are inept, or unresponsive, frequently require a longer personal oversight than the teachers can give. My position does not differ materially from that of head aide in any hospital workshop, except that as clinical assistant it has not been necessary for me to plan the work, to issue materials, or to keep track of the actual conduct of the teachers and apprentices.

Makes Clinical Report to Doctor

The initial work prescription is always made by the doctors. The teachers in the different departments report their difficulties to me. I make my personal observations and take these, with such advice and suggestions as occur to me, directly to the doctors. The teachers are entirely at liberty to go to the doctors with their own problems, but it simplifies matters to have the clinical report of the shop made by one person to whom instructions and suggestions may be given.

In this particular shop the teachers and apprentices, when they are not teaching, are supposed to be at work turning out products which represent a standard, and which, to a considerable degree, contribute to the income and upkeep of the shop. The teachers and apprentices have more time for such work by virtue of this new arrangement.

Before and after shop hours I have not infrequently an opportunity to prepare the patients for their work, to see that they approach it in the best possible way, and finally, to observe the after effects of the work more accurately than would be possible for the teachers, who, for the most part, do not live in the institution and so lose track of the patients except in working hours.

Those of you who have had much experience with occupational therapy will, I think, appreciate the opportunities of this position, and also some of its trials. The utmost cooperation is necessary between the teachers and clinical assistant. Any lack of harmony here would be fatal to the efficiency of the shop. The confidence reposed by the physicians in the clinical assistant must never be misplaced.

Must Have Enthusiasm for Work

My experience has taught me that such a position presupposes a considerable knowledge of technic in the various crafts, a sympathy which is intelligent, and a firmness which is not exacting. More than all else, it demands an enthusiasm for occupational therapy as a means of physical and nervous restoration, and as a background for the medical treatment of any long continued illness.

Above is the continuous occupational therapy chart in use at Devereux Mansion, Marblehead. In the columns at

the left are patients' names. In the column at the extreme right are names of departments of work. At the top (reading across) is the working time divided into quarter hours.

The doctor's first prescription for each patient is noted by inserting green pins in the squares to indicate length of working period. Rest periods or time devoted to other matters are noted by squares left vacant.

As the patient's time of work is increased, brown pins or some contrasting color are added. This shows at a glance what progress the patient has made in occupational therapy, and can readily be compared with the physician's observations of improvement. This ward or shop chart requires little time for upkeep. Besides showing the progress of individual patients, it gives a graphic indication of the work which the entire shop or ward is doing at any given hour in the day.

SUGGESTION FOR RECORD CARD

Miss Lena Lewis, director of occupations of the Pawling Sanitarium, Wynantskill, N. Y., writing in regard to occupational therapy record cards, suggests that in addition to the indication of the time given by the patient to work, there should be some statement as to his degree of contentment and apparent enjoyment of the occupation; also a statement of the value of his products and of the money return which he has received. She feels that these are clinical items and that they are important in the interpretation of the patient's hospital record.

Would it not be well to have on the back of the time record card suggested by Miss Dorothy Ross Carmer the following items:

Effort—excellent, moderate, poor.....
 Quality of work—excellent, moderate, poor.....
 Money return to the patient during the month.....
 Approximate cost of material.....

SHRINERS BUY SITE IN ST. LOUIS FOR HOSPITAL

It is announced that the site for the \$1,000,000 hospital for crippled children, to be built as a national charitable institution by the Shriners of the United States, has been purchased in St. Louis, Mo. It is in the Barnes Hospital group, with a frontage of 380 feet, and cost \$150,000. Erection of this hospital will virtually complete this hospital group.

The plans for a 150-bed hospital are being drawn, and construction will be started as soon as possible. The hospital will be for crippled children of the United States, regardless of religion or relationship to the Shriners' order.

OCCUPATIONAL THERAPY IN CONVALESCENCE OF WOMEN

By ELIZABETH MUIR, SUPERVISOR OF OCCUPATIONAL THERAPY, THE BURKE FOUNDATION, WHITE PLAINS, N. Y.

THE Burke Foundation opened its country convalescent institution six years ago with definite program and equipment for women's occupational therapy, as an important aid in restoring this class of patients to fitness for return to work-and-play life. The peculiarities and difficulties of this particular problem are incident to the short period of stay, averaging but three weeks, the first of which is not available usually for occupational activities. Upwards of 12,000 women and girls of all classes and diagnoses have been recuperated; and there has never, from the first, been doubt of the high value of our work cure; rather a constant extension and development of it.

Convalescent care is apt to be defective in two ways: the prevalent psychoneurotic weakness and deviation is not corrected; and too prolonged a period of merely resting leaves the person physically and mentally "soft" and unready for competitive living. The aim should be fully to carry the patient over the uncertain and markedly life-influencing time between getting out of bed and getting to work—to send the convalescent out "set up," and keen for social living. Gradually increasing physical and mental occupations, along with suitable recreations, are most effective in accomplishing this. Advice so frequently needed is: "We aim not to fatten you, so much as to strengthen, toughen and re-courage." Convalescent occupations are chosen and modified in view of these fundamentals.

In the brief residence with such widely diverse social, temperamental and disease states, it has proven best to have the occupations essentially compulsory. Nor is the particular kind of work so important as the doing of something for someone else, thus working gradually outside of self.

Certain unforeseen values have come with this therapy: occupational recreation is the best test of the patient's convalescent spirit and cooperative desire; likewise a test of prognosis, progress, and of final fitness. The group is bound to have a percentage of early dissatisfied and disturbing persons; if these begin to do well in occupation they do well otherwise, and succeed in

all round convalescing. Upon report and complaint, a first question is, "What of her occupation record?" Neuropathics and those of doubtful adaptability, the various border-liners, are earlier entered upon the work, and much waste of time and effort is thus avoided by aid of this trial measure.



Even the sewing classes are conducted out of doors, where the patients have the benefit of pure air along with the curative qualities of the work.

One hour per day, beginning at 10:30 a. m., is prescribed; in addition to the making of one's bed and tidying of the room, personal upkeep, mutual helps, etc. From



Flower gardening is part of the occupational therapy work at the Burke Foundation.

one to ten days of orientation are given before listing for the work: physician's excuse from it is thereafter required. Given in this way, it is taken as a matter of course, begun with some hesitancy and resistance often, but soon understood and enjoyed. Many need to be repressed from spending too much time and nerve force therein.

The occupation consists of (1) work for the institution's equipment and maintenance, (2) for the sales

department, (3) assistance and leadership in various lines. With a total population of over four hundred, the institution has gotten on well without a seamstress department. The patients (both men and women) have largely "made the place," and keep it in supply and repair and advancement. A partial list will sufficiently indicate the scope of the occupations: making and upkeep of all institutional linen, curtains, shades, pillows, cushions, table mats, towels; vegetable and flower gardening, vegetable preparation, lawn care, haying, snow cleaning; preparation of all surgical supplies for large dressing service; making of paper flowers, dolls, wax goods, rugs, and rug binding, loom products, baskets, photography, a varied line of fancy work, art decorating, etc.; "assistant" details, as in library, occupation and recreation; arranging and costuming for shows, entertainment in general, order and various



Even haying is not too strenuous to be included in the program.

appointed leaderships and committees, messenger service, office and cottage aides, etc.

The women's group numbers 150; twelve to twenty of these are girls from ten years up. About 80 per cent are at all times in prescribed occupation. Sewing and fancy work may seem to have too large a part in the régime, and many women justly object to this, at first, as drudgery they expected to escape from in convalescence; other kinds of work are then suggested, but these very patients usually come back to some kind of needle or fancy work, mainly to "kill time." Gardening, except the care and arrangement of flowers, has but moderate feasibility for short-term patients, because of the special clothing required, the dullness and lack of quick results; but the women are heartened and improved in general by physical work, especially out of doors.

Too many kinds of work are often attempted at one time. Best results come with alternations to suit particular abilities met with in the rapidly changing groups; much training-up, or fine quality of workmanship is not to be expected. Patients do not clean their rooms or assist in the dining service; but they carry on considerable mending, simple sick care, etc., for each other, and as energy increases they do things for themselves and their homes. The larger part of the handicraft work is taken to the cottages, and done much out of doors. Certain advanced and long-stay patients, as cardiacs and emphy-



Shoveling snow is one of the permitted occupations.

emas, go on "pay occupation" at twenty cents per hour, two to six hours a day, substituting in regular employees' duties or on equipment and repairs. From this they may grade understandingly into full employment here, or elsewhere.

Most of the occupational products are bought by patients and their friends, at prices covering cost of material plus 10 to 20 per cent for "overhead." Last year's sales amounted to \$2,000, which income is applied wholly to the Research Fund, for study and advancement in convalescent, cardiac, and allied lines; and this has proven most advantageous in giving clear understandings, and impulse to make, and buy, and give more. The occupation department is supported from the general fund, and thus given the status of an essential, like nursing or food.

The soul collects its mightiest forces by being thrown upon itself, and coerced solitude often matures the mental and moral nature marvelously.—F. W. Robertson.

THE BUREAU OF OCCUPATIONAL THERAPY

By RUTH WIGGLESWORTH, Boston, Mass.

The Bureau of Occupational Therapy was started in April, 1920, with a four-fold purpose. First: for the buying of materials for departments and individuals, making it possible, in spite of commission charged, to deliver at better than retail prices; second, for the sale of finished articles; third, for the exchange of designs and ideas throughout the country, (the Boston School of Fine Arts makes for, and gives to the Bureau any designs desired, which is the greatest possible help); and fourth, as a means of promoting service and of securing an understanding between the purchasing public and the hospitals, curative workshops and the department of district occupational therapy.

During the summer there were no headquarters, but the person in charge bought and sold for three hospitals to prove whether this could really be done to advantage. By fall there was evident need for a central room. This room was opened November, 1920, at 367 Boylston Street, Boston, Mass., and letters were sent to hospitals and aides asking cooperation.

The following experimental plan was determined upon. A charge of 33½ per cent to be asked on sales of articles, and 10 per cent on purchase of materials. It was then found that aides would like to join as individuals, so an annual membership due of \$2.00 was charged. Already, twenty-seven aides have joined, from the following states: Missouri, New York, Massachusetts, North Carolina, South Carolina, Ohio, Colorado, Michigan, Pennsylvania, and Minnesota.

Though the Bureau headquarters have been open but three months, the following have already in some way received help: The Massachusetts General Hospital, the Robert Brigham Hospital, Peter Bent Brigham Hospital, The Boston Consumptive Hospital, United States Public Health Hospital No. 44, the McLean Hospital at Waverley, Mass., Clinton Hospital, Boston City Hospital, the Memorial Hospitals, at Worcester, Mass., the Sanitarium at Clifton Springs, N. Y., the New York State Commission for the Blind, Department of District Occupational Therapy, Red Cross, Dr. Lord's Work Shop at Concord, Mass., Mr. Alexander Bell, Miss Snelling, Mrs. O. W. Tompkins, Boston School of Fine Arts, Boston School of Occupational Therapy, and others.

The Bureau is not meant to be a separate organization, but a helper for all occupational therapy workers. Time, and the cooperation of all desiring such a center, are necessary to bring it to its greatest usefulness.

If such a plan can be of service to anyone, wherever working, consider it yours. Give us constructive suggestions and state how this Bureau can be of the greatest help to you.

We believe that such a Bureau will have a real future, and that it can become an important link in the organization of occupational therapy. Address the Boston Bureau of Occupational Therapy, 367 Boylston Street, Boston, Mass.

TO DISCUSS EDUCATION OF AIDE IN JUNE NUMBER

The June number will include editorials and special articles on the education of the occupational therapy aide. This most vital matter is still widely open for discussion. It is too early yet to be final in our decisions or recommendations but not too early for the expression of opinion and for tentative conclusions. The educational number should be read by everyone interested in the future of occupational therapy.—EDITORS.

BIRMINGHAM UNION DOES IMPORTANT WORK FOR CRIPPLES

The Birmingham Cripples' Union, in Birmingham, England, covers five fields of activity: (1) visiting of hospital cases and after-care following discharge, (2) treatment in convalescent and nursing homes, (3) provision of surgical appliances and medical comforts, (4) friendly visiting of cripples in their homes, and the organization of occasional social entertainments, and (5) education and the apprenticing of cripples in various trades.

The Union was founded in 1899, though the work which it took over had been started in 1896 as a department of the Hurst Street Mission. In the first years the original idea of the committee of direction was to provide a connecting link between crippled children and the agencies which it was thought existed to care for them. No sooner had systematic visiting begun, however, than it was discovered that the existing agencies were by no means complete, one of the most important was missing, a convalescent home. Such a home was therefore started, but a few years' experience demonstrated that this was inadequate, that what was needed instead was a surgical and nursing home. As a result, "Woodlands" was opened in 1909, with a capacity of forty beds. Its accommodation has since been increased to 104.

The next need was for a convalescent home and hospital school to supplement the work done at "Woodlands." Through the aid of the *Birmingham Mail*, funds were raised and a house known as "Forelands," with seventeen and a half acres of land, at Bromsgrove was purchased. Two open air wards and one open air schoolroom are now in course of construction.

The society operates its own shop to make surgical appliances, so that necessary apparatus can be had promptly.

An orthopedic clinic is operated in Birmingham, growing out of the original work, still vigorously continued, of visiting and exercising general supervision over the crippled children of the city.

One of the most interesting features of the organization is its "Workmen's Auxiliary Committee," organized fourteen years ago to enlist a new type of interest and open up new fields of financial support. The first year this committee raised \$320; during the past year it has raised a sum of over \$8,000.

ILLINOIS SOCIETY OF OCCUPATIONAL THERAPISTS MEETS

At the annual meeting of the Illinois Society for Occupational Therapists, the following officers were elected for the ensuing year: president, Miss Katharine Staples, Psychopathic Hospital; vice-president, Miss Elsie Hassenstein, Cook County Hospital, recording secretary, Miss Helen McNeal, Vocational Committee for Shut-Ins; corresponding secretary, Miss Jeanette Beroltzheim, Marine Hospital; treasurer, Miss Winifred Brainerd, Presbyterian Hospital.

Before the business meeting, Dr. Neymann, superintendent of the Psychopathic Hospital, showed from a doctor's point of view what occupational therapy means in his hospital. At this hospital there is a large floating population of from 120 to 175 patients per week, 17 to 18 per cent of whom improve or recover. These patients enter the large wards on the third floor, where they are handled in groups. Occupation is given to them with the idea of improving the general morale of the wards, rather than giving special attention to individuals. The result is that the whole atmosphere of the place is changed;

the patients do not just sit around, because they have something interesting to do. Their attention is taken away from the fact that they are locked up. In other words, occupational therapy has proven very satisfactory, even indispensable. The situation here, he pointed out, leads to the problem of what shall become of the patient when he leaves the hospital. Some go to state institutions, where in the occupational department each patient helps to make his own group more productive, others go out into the world again, where they are not able to cope with conditions as they find them. An outside department which would work from an industrial standpoint is needed, said Dr. Neymann, so that a certain per cent of these patients could become self-supporting, and assets to the community.

THE BIBLIOTHEQUE ET MUSEE DE LA GUERRE SOLICITS AMERICAN SOUVENIRS

The "Bibliothèque et Musée de la Guerre," established by a vote of Parliament and placed under the direction of the Ministère de l'Instruction Publique et des Beaux-Arts, is the French official library and museum of the war. Its object is to collect, classify, and catalogue the more important documents, books, and objects of historical interest dealing with the war, its causes and results; to preserve for posterity the complete record of these crucial years in the world's history.

The aim of the library is not only scientific research, but also popular instruction. The library is open to the public; temporary and permanent exhibitions are arranged in the museum.

The library collects the official documents of all the governments, belligerent and neutral; books and pamphlets dealing with the various aspects of the war, publications of auxiliary and volunteer organizations, magazines, newspaper reviews, propaganda, maps, letters and diaries, statements of prisoners, etc.

The museum collects pictures, stamps, posters, drawings and sketches, photographs, models, games and toys made by the wounded, knick knacks and the intimate souvenirs of all kinds associated with the armies of the prosecution of the war, or reflecting the life of the people in war time.

The large collection which M. and Mme. Henri Leblanc began in 1914 forms the foundation for the present library; their patriotic activity and bequest have secured for this institution much valuable material. That the success of the undertaking may be complete, the generous cooperation of all who possess objects of historical value is invited.

The British and American section, being of recent creation, is still very small and incomplete. It is the desire of the director to make this section thoroughly representative of the mighty and victorious efforts of the British Empire and the United States. Regular donations to the war library and museum, forming a lasting monument to the British and American nations, will make still more intimate the friendship between France and her allies.

All communications and material should be sent to the following address: Mr. le Ministre de l'Instruction Publique et des Beaux-Arts, Bibliothèque et Musée de la Guerre, 39 rue du Colisée, Paris (8ème).

The Bureau of War Risk Insurance announces that the sum of \$1,154,911,719 has been paid out in death claims, and \$29,577,540 for disabilities, during and since the war. The Bureau had issued \$400,000,000,000 in war risk insurance up to August 31.



HEALTH AND MODERN INDUSTRY

PHYSICAL EXAMINATION AND RECONSTRUCTION*

BY A. A. BUREAU, MANAGER, INDUSTRIAL RELATIONS DEPARTMENT, MORRIS & Co., CHICAGO, ILL.

ONE of the great problems today before the industrial committees of big industry is to determine the exact place physical examinations should occupy in the selection of employees. In the past we have hired men upon the basis of education or skill. In this day when physical examinations, army and industrial, are so common, we are beginning to realize that there is still another great factor in the hiring and placing of men. A man's mental alertness, soundness of judgment, or efficiency and skill in his trade depends, to a large extent, upon his physical condition. A man in poor health is like a dirty machine. He cannot make his body respond quickly in the face of impending danger, nor can he do his best, regardless of how good the working conditions may be. As to safety, an abnormal man is never 100 per cent mentally or physically alert. Such a man decreases the safety of his fellow workers. Accidents are costly misfortunes, both in human suffering and cold cash. As to efficiency, anything less than his best reduces the production of that department. The loss in production caused by the physical health of one man, when multiplied by many such men, soon can make a marked difference in the total amount of production for the plant. Therefore, the physical condition of the employees is an important factor: (1) in the reduction of accidents, and (2) in the cost of production.

Will Have Wider Application

Looking upon physical examinations as one means of controlling the number of accidents and the cost of production, I believe that the place of the physical examination department shall be looked upon more and more as an absolutely essential part in any well regulated industrial organization. Also, as time goes on, there will be more emphasis laid upon the grading of workers as to their physical fitness to perform the work of the particular job for which they are hired. In industries where there are no physical examinations, they will be required, and in industries now conducting such, the work will be done with more care and precision.

Physical examinations as now conducted in army, civil, or industrial life, are to keep out the physically unfit from a particular organization. The army refused the imperfect man, the life insurance company rejects the poor risk, and the industrial organization turns down the man liable to be injured at his work. Then we have the just passable

class in industry which may be in the unfit class of tomorrow. Our physical examinations, accordingly, in the future, must take on a broader scope—in other words, if they are to serve the community and industry as a whole they must build up some form of reconstruction work to be followed among their employees.

These are, in brief, the reasons why physical examinations have a place in industry. They give a glimpse of what their future must be, and bird's-eye view of their present status. We may now examine step by step how we provide for the safety of our employees in the elimination of the unfit and in medical reconstruction.

The first step in the elimination of the unfit takes place in the employment office. It is the duty of the employment manager to hire those he deems good risks of industry, that is, men who have the necessary strength and energy to safely perform the duties of the jobs open, and to pass up the rundown and the physically unfit otherwise. This may seem a divergence from the subject, but it is a very important step and must not be overlooked. The doctor's office is not then made a weeding-out station. The doctor must ever stand as the friend of the plant workers; in fact, he must take the place of the employer, as the caretaker of his injured employees. In the olden days, in case of an accident, the boss went personally and looked after his hired man; but the times and conditions have changed with the rise of big industry. In his examinations, the examining physician must stand as a reconstructionist, if confidence is to be placed upon his advice for the physical upbuilding of the one examined. If the doctor is seen as their true friend in the time of their physical disability, there can be no more powerful influence in the getting of the good will of the employees. Therefore, the doctors should be called upon to reject very few men, in fact, only in case the disabilities are masked or denied. The employment manager must be held strictly accountable for the class of men he hires. It makes a much better impression with labor to pass up a man than to have him rejected because he cannot come up to the company's set rule. Under no circumstances should the employment man be allowed to pass the buck to the doctor's office for the rejection of all the unfit.

After the hiring of the applicant ultimately comes the physical test for fitness. The examinations may be conducted immediately and before the man goes to his job, or after he has been on his job for a few days. We examine our men after they have gone to work. Several obvious reasons present themselves for this procedure.

*Presented before the Ninth Annual Safety Congress, Milwaukee, Wis., October 1, 1920.

First, it is easier to induce the men to go to work. They do not have ever in their mind that immediately following the acceptance of the job they will have to be subjected to a physical examination—a thing often repulsive to the workers. This way they will be given a chance to see if they like their job and want to stay with it. Our experience is that the men don't object to the physical examinations after they are hired. A refusal is a rare thing. These are usually among the ignorant whites. Second, the examinations can be made more thoroughly and will be of greater benefit to the employees. Our big hiring day is Monday. The rest of the week is slow in comparison. Thus, if the doctor had to examine all of Monday's applicants on Monday, he could give them only a very superficial examination. In very few cases could he actually take time to give advice. If the doctor has more time, he can advise each one personally. Also, he will have only as many as he can handle by calling the applicants from their work. Third, examinations on which the doctor can spend time and give adequate counsel create loyalty to the company, and give the man a view that the company doctor is a real friend, not one who does just as little as possible because he is a company doctor.

How Work Is Managed

The calling of the men up to the doctor's office is an ordinary matter of routine. The time office furnishes a list of the additions, transfers, and take-offs from the pay roll to the examining physician's clerk. He makes up a list of the men required for examination. The record card of those transferred is automatically renumbered and refilled. The record cards of the take-offs are removed from the live file and placed in the dead file. The list of the unexamined is sent to the different foremen by a messenger boy who goes to each and notifies him of the men he is to send to the doctor's office that day. The foreman gets a duplicate copy of the list and puts his name on the original list to show that he has been duly notified, and he is thus held responsible for sending those men to the examining room that day as he can spare his men. With each man is returned an "O. K." card to show the foreman that the man has been to the doctor's office, examined, and accepted.

The examinations are conducted more or less on the army routine. We have the applicant remove his clothing. Every irregularity is diagnosed and noted on his record card. The examinations are thorough in every respect, and at the bottom of the card is noted our opinion of the safety risk and fitness of the applicant.

During the month of July we made some rather broad studies of our physical examination findings, based upon the record cards of 855 men. It rather startled us at first to find so many defective men; however, in a study made by a life insurance company, it reported only a little over 2 per cent of the men they examined were found perfect. Out of this 855, we found sixty-eight men, or 8 per cent, had some defect of the hand or arm, such as amputated fingers, stiff joints, rheumatism, cut tendons, etc. Thirty-three men, or approximately 4 per cent, had some defects of the feet, as bunions, deformed toes, amputations, etc. Fifty-eight men, or about 7 per cent, possessed some varicose veins which, in most cases, are not now serious but may, in old age, be a very serious annoyance. Two hundred and sixty-two, or 30 per cent, were afflicted with flat feet, which includes varied from slight to extreme flat feet. One hundred and fourteen men, or 13 per cent, had some form of organic heart disease. Seventy-seven, or 9 per cent, possessed either umbilical, single or

double hernia. Seventy-six men, or 9 per cent, had hemorrhoids. Nine men, or 1 per cent, were found to be blind in one eye. Taking 20/40 as a basis for poor vision, sixty-five were found to have poor vision in one eye; and ninety-seven, or 11 per cent, to have poor vision in both eyes. Also, we found sixteen other defects of the eyes, such as strabismus, cataracts, nystagmus, ulcers of the eye, etc. Six men were found with some form of venereal diseases. In most of the cases, the defects were minor and did not affect the efficiency of the worker to any great extent. However, they make him liable to accidents.

In a more recent examination at our car shops of one hundred and eighty-two men, we found fifty-five defects which made the men employed in a more or less risk to the company. Of this number of men, we classed one hundred and forty-two men as good safety risks. Thirty-four men as fair safety risks—that is, they were passable, and six were classed as poor risks, or below the standard to be employed.

Causes for Rejection

The causes for which we reject men are: (1) contagious diseases of various sorts, such as venereal diseases, tuberculosis and skin rashes and eye diseases. (2) Poor safety risks. This includes those who are more or less a safety risk to the plant, endangering their own well being or that of their fellow employees. In this class are hernias, very poor vision, paralysis, fits, and the like. When possible, we place this class of men in positions that do not require the same energy or strength as the ordinary job. (3) The physically undesirable, those who should not work at some particular class of work. This includes those with weak lungs in the fertilizer or hair house, rheumatic people in the pork room, tripe room, or freezers, where there are wet and cold conditions. In most of these cases we try to find something else open in our plant where this individual may work without injury to his health.

Our physical reconstruction work may be divided into three different classes: (1) Medical advice (a) advice regarding simple medical treatment which they can do for themselves, and (b) advise as to the work which they can and cannot perform to their physical well being. (2) Medical and surgical aid. (3) Advice and instruction as to free dispensaries.

For minor medical cases we often write a prescription. In many cases we recommend something that the man can buy at the drug store at a very small cost. This applies to skin rashes of a non-contagious nature, bronchitis, colds, etc. In the case of bad varicose veins we either recommend that the man have an operation for the same or wear a rubber stocking.

In the heart cases the men are given advice as to what kind of work they can do with safety to their health, and also general advice, such as to avoid running upstairs and the like.

Venereal cases are simply directed to go to a good physician and get a permanent cure or go to a government or city dispensary and get the proper medical treatment there; also to avoid quacks. In no case do we allow them in the food producing departments.

For hernias we advise operation. The young man we especially recommend an immediate operation while he is young and can easily undergo the operation. In the case of an old man we recommend that he get a truss. In all cases we require either an operation or the wearing of a truss before they come back to work.

Such examinations disclose a lot of men who have not

been vaccinated, especially among the colored, and we require vaccination either by their own doctors or the examining physician.

In case of failing vision we lay strong emphasis upon their securing the proper glasses. If they haven't the money to purchase the same, we send them to an eye dispensary where they only have to pay for the lenses.

The degree of ignorance prevailing among the ordinary workmen is appalling as to where he can get free medical attention without cost or expense to himself. In most cases, this free medical attention is far better than he could afford. In the large cities there are hundreds of free dispensaries for every kind of an ailment, dental, eye, operative, skin, lung, medical, etc., but they often fail to reach those in need of such services.

Many workmen have serious defects often unsuspected by themselves. Many come in who have no idea as to the condition of their lungs, others as to their heart, etc. Most workmen do not realize the seriousness of having hernia. We question them about it and advise the proper treatment, and they will come back invariably with the statement that it has never bothered them. Many would rather quit their job than buy and wear a truss. Many do not suspect at all the presence of hernia, even when of fair size, until it is brought to their attention. In one case, especially, the old colored man said to the doctor, "I got a swelling and I've been putting everything on it, salve and poultices, and it won't go away." What he had was a hernia.

Then there should be physical examinations of the old employees at intervals to reveal if there is an approaching disease. Many a disease, if detected at the beginning, can be forestalled or warded off. The great trouble is that most workmen allow the disease to get a great hold upon them before seeking proper medical service, as borne out by statistics which show that 650,000 workmen die every year from preventable disease.

The finding of the unsuspected defects is the greatest good that can be derived from a physical examination department. Only in this way can the man, his company, or the community be able to help in maintaining his good health. If for no other reason, this aid to the individual employee justifies the existence of physical examinations in every industrial organization. Then the placing of men in jobs according to their strength and energy often saves the loss of life and limb. The saving of one life is worth the necessary expense of a whole department.

Our experience would lead us to say that the hiring of men under a physical examination system is the only way of intelligently employing men. When the employer does not know the fitness of his men or the men do not know their own fitness, it is as if the blind hired the blind. Physical examinations are not conducted to bar men from industry, but to place them where their own well being is not endangered. Only by the examination system can the employer get at his men to carry on any kind of physical reconstruction work among his employees. From the viewpoint of efficiency, physical examinations are essential. Industries where they do not place their men according to their physical fitness pay very heavily for weak help. From the viewpoint of safety to the employees, physical examinations are not only absolutely essential, but should be required by the community for its own protection. No industry, because of its lack of oversight over its employees' physical condition, has a right to turn out men upon the community crippled and inefficient, to be more or less a public charge. Physical examinations pay from every point of view—safety, efficiency, humanitarian, and cold cash.

CALIFORNIA ASSOCIATED RAISIN COMPANY DENTAL SERVICE

By H. L. BROWNELL, D.D.S., Fresno, Cal.

THE medical supervision of the employees of the California Associated Raisin Company is conducted under the auspices of a self-organized, self-conducted organization on the part of the employees themselves. The plan was furthered by the earnest efforts of some of the officers of the company. The organization was effected under the Sun-Maid Welfare League, and the membership now is more than three thousand.

At first the League was intended to cover medical service only; but when the urgent need for dental care became apparent, this feature was included among the other benefits. It was at first thought not to be necessary to maintain a dentist at the plant and the plan was tried of putting out the work of dental prophylaxis, and necessary extraction, to dentists resident in the Valley near by the several plants. It was soon found, however, that the employees did not avail themselves of the service under this arrangement, and a plan was worked out through the cooperation of L. R. Payne, superintendent of the company, whereby the service was extended and was at the same time made more readily available to the employees.

A dental office was opened in connection with the medical clinic, and the author, as dentist in charge, spent three days a week there. Nothing but cleaning, extracting and the handling of emergency work was undertaken. Fillings, bridge work, etc., are all referred to outside dentists. The work includes a talk to each patient on oral hygiene before he is dismissed.

Recently the company erected a new plant, the new installation including a dental and surgical clinic. A registered nurse is in constant attendance. The dental clinic is unusually well equipped, its apparatus including a Ritter chair and engine, a Clark cuspidor, a Pelton and Crane electric sterilizer, wall bracket, and an enamel table to work from. Everything is finished in white.

Complete records are kept of the number of patients treated and the nature of the work which is done. In this branch the cases average ninety per month, which number includes about thirty extractions and twenty-five emergency treatments. Every patient coming in for treatment has his teeth thoroughly cleaned. The clinic is open from nine to twelve every Monday, Wednesday, and Friday for ten months during the year, the plant being closed usually from July 15 to September 15 of each year. The work is gradually being extended and has been of inestimable value in the general welfare work of the plant.

HEALTH WORK BECOMES PART OF INDUSTRY

The National Industrial Conference Board states in a recent report that health service in industry has become an integral part of the industrial organization. In a recent investigation made by the board, it was found that thirty-four plants, representing fifteen industries, employing 400,000 men, have introduced physical examination of workers to great advantage.

WILL ADDRESS MEETING

Dr. Max Kahn, director of laboratories, Beth Israel Hospital, and associate professor of biological chemistry, Columbia University, New York City, will address a meeting in the interest of the Illinois General Hospital on May 12, in Chicago.

VENEREAL DISEASES AND THE HOSPITAL

Conducted by ALEC N. THOMSON, M.D.

Director, Department of Medical Activities

The American Social Hygiene Association, 105 W. Fortieth St.,
New York City

THE HOSPITAL'S RESPONSIBILITY IN THE VENEREAL DISEASE PROGRAM

THE All-America Conference on Venereal Diseases, which met during the week of December 6-11, 1920, for the purpose of bringing together recognized authorities in the various fields of venereal disease control, and making possible a comparison and evaluation of the methods of venereal disease control employed in various parts of the world, went on record with the statement that:

"Hospitals should do their part in the program for the control of venereal diseases by recognizing them as serious diseases worthy of skillful diagnosis and treatment without discrimination."

It follows, therefore, that hospitals not only have a definite part in the program for the control of the venereal diseases, but are neglecting this responsibility when they fail to offer adequate facilities or openly, or in any other way, discriminate against venereal disease. And the conspicuous scarcity of beds for cases requiring treatment in hospital is simple evidence of failure in this responsibility.

As a matter of fact, general hospitals do accept many patients with gonorrhea and syphilis in an active stage, but on account of a complicated or intercurrent disease and not on account of the gonorrhea or syphilis. Therefore, they might just as well accept them as venereal disease patients.

It is necessary here to establish a clearer distinction between quarantine of infectious persons for sanitary and public health reasons, and custodial care for those who offend against the laws relating to prostitution and allied subjects. The general hospital is an institution rendering medical service to the sick of the community, and not one for custodial care of incorrigible individuals. Persons in the infectious stages of gonorrhea or syphilis, who refuse to observe the simple precautions required for the protection of the community, should be quarantined by public health authority while a menace, and should be given adequate treatment while in isolation. Individuals that offend against the criminal code belong in institutions established for their care and rehabilitation, where, again, they should be adequately treated for any existing disease or disability, including venereal disease. If, then, from the standpoint of the sanitary code, we exclude from hospitals those who require quarantine, and from the standpoint of the criminal code exclude those who require custodial care, we have left only a comparatively small percentage of patients that require admission to hospitals as sufferers from gonorrhea or syphilis.

Moreover, the medical profession is agreed that syphilis does not differ as a communicable disease problem from pneumonia or typhoid, and that in handling gonorrheal cases the hospital needs merely to consider the problem of the patient having an infectious discharge. Patients suffering from venereal disease are at times, and for various reasons, in serious need of bed care. They should be considered by the hospital under the same admission rules as typhoid or infected surgical cases. In general it may be said that gonorrhea and syphilis do not require anything more than the simplest precautions against infection. In the hospital that observes good technique, cross-infection rarely if ever occurs. Such cases as occur are due only to gross negligence, ignorance of the patient's condition, careless attendants, or some other preventable factor.

The Conference outlined the following special requirements for the care of venereal disease in the hospital to the best advantage of the patient and the hospital, and the furtherance of the venereal disease program:

1. Facilities for adequate concurrent disinfection such as are required in the case of pneumonia, tonsillitis, or typhoid fever; i. e., sterilization of dishes, utensils, etc., used by the patient, and disinfection of discharges and articles which may have been contaminated.
2. A ward dressing or operating room for examinations, dressings, and minor surgical procedures.
3. Such special instruments as are required in the ordinary practice of genito-urinary surgery and syphilology.
4. Employment on the staff of specialists or at least the best skill available in the community.
5. Adequate records, which should contain as a minimum amount of data the following: (a) census date; (b) data as to date of infection, geographical source of infection, social status of infected person, medical prophylactic measures used, if any; (c) concise but sufficiently definite data to support this diagnosis; (d) laboratory findings; (e) definite notes on treatment, progress, and conclusion of the case; (f) social data.

To further aid the program for venereal disease control, the Conference considered:

That there is no advantage in having a venereal clinic separated from a general clinic when the circumstances are such that a general clinic can be maintained.

That the advantages of having the venereal disease clinic operated in conjunction with other clinics and under the direction of a trained personnel are as follows:

1. It promotes recognition by the public that venereal

diseases are being dealt with exactly like other diseases; this is of great value in bringing about a proper attitude on the part of citizens in general toward the prevention and control of these diseases.

2. By placing the treatment of venereal diseases on a parity with that of other diseases it tends to establish a precedent for the admission of these patients to general hospitals on the same basis as other patients.

3. The treatment of venereal diseases in the same institution with other diseases promotes a better understanding on the part of young physicians, especially interns and medical students, regarding the importance of these diseases, and of the true relationship between them and other pathological conditions.

4. The cost of operating a venereal disease clinic is much less when combined with a general clinic where the services of consultants, attendants, and other personnel, laboratory facilities, complete medical and surgical equipment, quarters, and general utilities are available without commensurate increase in overhead expense. When the venereal disease clinic is maintained separately it is more difficult to obtain the services of internists, neurologists, ophthalmologists, etc.

5. More patients will seek treatment at the general clinic because: (a) Many patients are not aware that they are infected with venereal disease when they apply for treatment; (b) the established general institution is more likely to gain and hold the confidence of its patients; (c) the patient attending the general clinic is not thereby stigmatized as a venereal disease patient, as might be the case if he went to a clinic exclusively devoted to venereal diseases.

And to complete the hospital's responsibility in the venereal disease program, the basic principles of medical social service were declared essential to the efficient organization of venereal disease control work, and of value to:

1. The patient, through improving morale, removing obstacles to attendance at clinic, and sustaining the interest of the patient in continuing treatment.

2. The hospital and clinic, through aiding in administration, developing the efficiency, and broadening its scope as an educational center, and in helping to create a friendly spirit of service.

3. The community, through work concerned with the immediate control and elimination of individual cases, in addition to influencing by obtaining and aiding in the dissemination of information, the progress of the local venereal disease campaign in its broader aspects.

The social record sheet of the venereal disease patient should contain information that will be of assistance in: (a) doing "follow-up" work; (b) tracing contacts; (c) tracing sources of infection; (d) estimating the value of educational methods in vogue as part of an anti-venereal campaign; (e) demonstrating the social needs of the community, e. g., recreational needs, housing needs, industrial conditions, and the like; (f) demonstrating economic loss to various industrial and other units in the community; (g) demonstrating the distribution of infection; (h) demonstrating types of prostitution, extent of solicitation, etc.

The importance of venereal disease as a national menace is rapidly becoming known to the general public. In the specialized field of public health it has received recognition in the past few years as the greatest single health problem now confronting the country. The strategic position held by the hospital, and by the dispensary as a part of the hospital, has not been fully understood or appreciated by those engaged in the management and

maintenance of the hospital from the financial, administrative, or medical point of view.

The opportunities of the hospital as a teaching institution in relation to the control of venereal disease are unlimited through the general patient population, through the non-professional employees, through the nurses' school, through the training of interns, through the post-graduate instruction of physicians, and through the research and experience gained by the attendant staff.

STUDY OF SYPHILIS CASES

Archives of Dermatology and Syphilology for March, 1921, has an interesting and valuable article by Drs. Udo J. Wile and C. H. Marshall. It is a study of 1,869 cases of syphilis in all stages. The routine lumbar punctures have been carried out upon these patients and the associated findings have been carefully studied. This number is about one-third of the total number of cases seen. They have been selected particularly with reference to correct diagnosis and have been accurately observed over a definite period of time.

As a result of this study the authors made the following conclusions:

1. The nervous system, if uninvolved as shown by the accepted criteria during the first months of infection, is seldom invaded later. A negative preliminary puncture followed by positive findings at a later date occurred in only three of several thousand cases punctured.

2. Of the several criteria indicating involvement, the increase of organic solids is found to be slightly higher than either cell count or the Wassermann reaction, the relative value being indicated in the order just mentioned.

3. A considerable degree of cerebrospinal involvement may be present in the latent period of syphilis without manifesting any signs or symptoms.

4. Such asymptomatic cases may become symptomatic later, and a study of the colloidal gold curve in these cases is of some value in estimating the ultimate prognosis of the case.

5. Comparing the large number of cases of primary and secondary syphilis in which positive findings are found, with the relatively small percentage of late neurosyphilis as compared to total syphilitic incidence, we must conclude that a large number of early cases are in the nature of meningeal roseola, which is transitory in its clinical aspects.

6. The interpretation of the lumbar puncture findings, particularly early in the incidence of the disease, constitutes a valuable guide in estimating the ultimate prognosis of the disease with regard to the integrity of the nervous system.

VENEREAL DISEASE CAUSES ACCIDENTS

One of the largest telephone and telegraph companies in the United States has discovered that compensative accidents that happen to its employees bear a marked relation to the incidence of venereal disease. A large proportion of accidents to linemen, for instance, has been found to mark the beginnings of locomotor ataxia, a diagnosis which is almost always camouflage for syphilis.

SOCIAL AND MEDICAL WORK COORDINATE

In all hospital social service work it should be remembered that this department is coordinate with and an aid to the medical division of the hospital. Social service work should be thought of as a therapeutic aid to the patient's welfare, helping him to return to civil life and fill his place in the community.

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR.

Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, and Chief, Service Bureau on Dispensaries and Community Relations of Hospitals, American Hospital Association, 15 W. 43rd Street, New York

WHAT A LOCAL HEALTH CENTER MEANS

BY MARY BEARD, R.N., DIRECTOR, INSTRUCTIVE DISTRICT NURSING ASSOCIATION, BOSTON, MASS.

"THE term 'health center' has been very loosely used as a name for everything from a milk station to a miniature health department. A real health center should be a complete health department. In a small city the health department should be the health center; in larger cities health centers should be established for the purpose of decentralizing official health activity and linking with it every agency carrying on public health activities within the area. It should also serve as a common headquarters in order to effect the closest cooperation with workers for sociologic and economic betterment.

"To operate successfully, the health center must have official status, and in addition to the diagnostic and dispensary facilities, the public health nurses and other official personnel, it should house the liaison officers, when necessary or advisable, from unofficial or voluntary agencies. It must be remembered that one of the most useful results made possible by a properly conducted health center is the creation of a real community spirit which will furnish the popular support necessary for success in public health work."

The health center of which I wish to write is situated in a locality which may be described as a town of 23,000 inhabitants. On three sides it is adjoined by towns outside the metropolitan area and its only geographical connection with the rest of the city is by means of a narrow strip along its lower border.

There are quiet residential sections with comfortable homes, no homes representing enormous wealth, and none of abject poverty. There are a good many factories and the number is increasing. The men and women employed in the industries are, on the whole, well paid, their homes comfortable and not too crowded, and many have gardens. There are good shops, schools, churches. The water supply and sewerage system are excellent; the milk supply is as carefully protected as in the neighboring parts of Massachusetts, and there is the same police and fire protection and sanitary inspection.

The population is composed of American born families, many of whom have lived here for years, and a good number of foreigners, brought in by the industries. But the foreigners are for the most part thrifty, and ambitious to have good homes, and many now own their own. There are Italians, Poles, Lithuanians, some Jews, a few Syrians, and an occasional French or colored family.

There are in the town no hospitals (except two very

small private ones), no clinics for diagnosis and treatment of minor illnesses, and the early correction of defects. Doctors are called only when there is definite illness and are discharged as soon as the acute stage is past.

The first connection which was made by the nursing association was in 1912, when this town was annexed to the city. The nurses of the association were giving nursing care to the policyholders of the Metropolitan Life Insurance Company in the city, and when P— became a part of the city, this service was extended to its policyholders. The nurse went out from the central office of the association each day and had no office or place for supplies in P—. The following indicates the variety of appeals which were made to her. One day when she was hurrying along she was stopped on the street by a young Italian in deep distress. From his excited gestures and torrent of imperfect English, she gathered that a birth was about to take place. "Oh, Signora, she die, she die! I send for doctor, two three times. He no come. Oh, she die, she die!" There was, of course, nothing else to do but go, and she followed him across the fields and up through the woods. As they approached a tidy little house, the nurse anticipated the snowy, lace trimmed bed usually found in an Italian home. To her surprise, the man walked past the house to a shed in the rear, and there, in throes of labor, on a bed of straw, her eyes looking up in mute appeal, lay Tony's pet goat!

Effort to Arouse Local Interest

During the next three and a half years the work developed rapidly and a local committee was formed, which assumed the responsibility of interesting the people, locally. The policies governing the work were determined by the board of directors of the nursing association. Two members of each church, including the Jewish synagogue, were chosen as members of this committee, but this plan was discontinued later. The present committee does not place emphasis on church or creed, but its members represent varied community interests.

The health center which is being conducted in P— took care of over 3,000 people last year, about 13 per cent of the entire population of 23,849. This figure covers all types of cases, acute and chronic medical, surgical, prenatal, maternity, dental, well baby, and well child.

In most instances there were at least two members of the family under care, while the other three members of the family (taking an average family) were of course seen and observed by the nurse. Therefore, it is esti-

1. Allan J. McLaughlin: Standardization of Municipal Health Organization; Public Health Report, p. 1035-1039; April 30, 1920.

mated that the nurses actually reached about 33 per cent of the entire population.

The running expenses during this period were around \$15,000, of which 20 per cent was met by fees from patients and from an insurance company. The remaining expense was met by this association and a very active local committee. This expense amounted to \$3.74 per person cared for. The entire expense per person cared for, had there been no collection of fees or insurance work, would have been about \$5.00.

If the deficit which was met by the nursing association and the local committee had been met by the entire community, it would have amounted to about fifty cents a year per capita for the entire population.

In 1916 the nursing work in P— had developed enough to warrant establishing an office there. In December of that year an office was opened with one supervisor and four nurses. The outstanding health needs were prenatal and maternity nursing care for mothers and new-born babies, and a well baby conference with enough nurses to follow up the babies, visiting the mothers in their homes. These services were established. Prenatal nursing for patients under the care of any local doctor proved its value and grew steadily. In 1917 in P— 1,134 prenatal visits were made, and in 1920 the number increased to 3,093.

At the baby clinic there is always in attendance a doctor who is a pediatric specialist, and he is paid a moderate fee for his service. One of the committee members has assumed the responsibility of attending each clinic and she is not only a great help to the nurses during this busy time, but gives an atmosphere of hospitality which the mothers are quick to appreciate. She has known some of them since they were children themselves, and she has a faculty for remembering the new ones. In speaking of the development of the clinic, she says: "My impression of the early clinics is that the mothers were mostly Italian, their babies swathed and bound in old world fashion. Now the mothers are of all nationalities and in some cases we are caring for the third baby. It is a rare thing now to see a baby in a long binder. I feel that the nurses are loved and looked upon as an authority in the community."

In 1917 a factory employing some one hundred and fifty men and girls asked the nursing association to supply a nurse one hour daily for first aid work and health instruction in the mill. This work continued without

interruption to the present time, when shortage of work has closed the mill.

The nurses continued to feel the need of more facilities for dental care, for while the school nurses examined the teeth of the children in the public schools, above the second grade, the younger children and those in the parochial schools were not examined. The nearest clinics necessitated a long ride, changes of cars, and two car-fares. In March, 1918, a dental clinic was opened in the station, a graduate dentist procured for three days each week, and two full-time dental hygienists.

In August, 1919, the dental clinic was resumed on a different basis. It was made available to any member of a family whose income did not exceed \$4.00 per week per capita. No gold fillings or plates were attempted, and no work under anesthesia. The charges were very moderate, representing more than the cost price of the material, but not covering the amount paid the dentist. There was a little newspaper publicity for this, but most of the patronage was and still is secured through the personal work of the nurses in the homes. There was a splendid response from the first, parents welcoming the chance to get their children's dental work done at a price within their means and without paying two car-fares. The nurses soon felt that the per capita rate was keeping out some families whose income did not permit a private dentist, and the board of directors raised it to \$6.00. The dentist is busy two days a week and there are always appointments several weeks ahead.

The health activities of P— have developed as rapidly as funds were available. The latest developments, made possible by a gift from the American Red Cross, are the maternity and hourly nursing services. These were

started July 1, 1920, by the addition of two nurses to the staff. They live in the district and are available for maternity service day or night. The doctors have welcomed this service, but the best response has come from the patients themselves. The fee of \$5.00 gives the patient the services of the nurse to assist the doctor at time of delivery. Subsequent nursing care is given by the regular district nursing service.

Recently there has been added a clinic for the older children called the Child Health Clinic. The clinic is held on the same afternoon as the Baby Health Clinic and at the same hour. A pediatrician is present and he is paid a small salary by the District Nursing Association.

ANNUAL REPORT FOR 1920

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He has with him one or more postgraduate medical students. The children are given a thorough physical examination, are weighed and measured, and their mothers advised. If they should become ill, they are subject to the policy which guides us in our conduct with all other ill children. That is, the district nurses make the proper connection between the family doctor and the sick child.

The daily planning of the nurses' work requires eternal vigilance and quick readjustments. With one group of nurses handling so many activities, it is so easy to over-emphasize one at the expense of another. When Tommy Brown has pneumonia, it is not difficult to get so interested in him that the preventive and instructive work lapses a little.

The supervisor writes, "Yes, work in P— is different and has many difficulties. We wish we had a diagnostic clinic, sometimes we wish we had a treatment clinic, or at least a 'free' doctor, and we very much want a pregnancy clinic. But we don't envy the other districts who have all these things, because we have a well baby clinic and a dental clinic and they haven't, and we do generalized nursing, and unless you have done it, you don't know how satisfying it is." Another thing that helps the supervisor is that the nurses do these varied and often difficult things as a matter of course. When asked for stories to illustrate the preventive character of their family work, they always say they have none, so much have the different activities become a part of their daily routine. The following story illustrates the opportunities which generalized nursing offers to the nurse for following out the myriad details necessary to procure or at least approach positive health in these families.

The nurse became acquainted with Mrs. D. through visiting John, who was a well baby a year old. Mrs. D. was not very responsive, as she felt John was doing very well. The nurse continued to call, and after a few visits she ventured to speak about the teeth of the older children. When she told about the dental clinic there was a quick response and Mrs. D. sent them for dental appointments at the clinic before the week was over. Then she became interested in the condition of her own teeth and with a little urging went to a private dentist, as the clinic dentist does not make plates. With the help of a relative she was able to pay for a set of teeth, and her general health has improved since. During this time she was becoming more responsive and followed the nurse's advice about John's diet. Later she told the nurse she was in the early months of pregnancy and was glad to receive the nurse's prenatal care. As she became better acquainted she told the nurse that Mr. D. was not well, that he lost a good deal of time from work and was cross and disagreeable. When the nurse talked with him she was convinced that he needed medical attention, but it took a long time to persuade him to go to a dispensary for examination. He finally went; a diagnosis of hemorrhoids was made, and he was successfully treated. He was also advised to take lighter work because of hernia. For a time he stubbornly refused to consider this, but when he finally consented it resulted in a small increase in salary. He is now working steadily, he has not lost a day in seven months. Incidentally, his disposition has improved and he is decidedly more agreeable. Happiness and self-respect have been increased as the health standard has been raised.

DISPENSARY ORGANIZATION

SUMMARIZED FROM THE FINDINGS AND RECOMMENDATIONS OF THE CLEVELAND HOSPITAL AND HEALTH SURVEY.

1. The final governing authority of the dispensary should be a board of trustees. If the dispensary is an out-patient department of a hospital, the board of trustees of the hospital will serve as such authority. No member of the board should be a member of the active or consultant medical staff of the dispensary. Dispensaries which are under a religious or public city or Federal organization and which cannot, therefore, have trustees, should appoint an advisory committee similarly constituted. In addition to the men members of the board of trustees, who represent chiefly financial, administrative, and broad public interests and experience, it is of much importance that there be included on the board of trustees a representative of some institution of higher education, viz.: university, normal, college, and women members whose experience and interest can be relied upon to contribute constructive ideas and opinions.

2. The appointment of the medical staff should be vested in the board of trustees. Appointment should be made for terms of one year, renewable by the board. The nomination should be made on the initiative of the board of trustees or of the medical staff or of an executive committee of the medical staff. The board of trustees should consult with the superintendent, or chief executive officer, before confirming the nomination of a medical staff, or of individual members thereof.

The following two paragraphs refer to dispensaries which are not parts of hospitals.

3. The medical staff should be definitely organized for the promotion of teamwork, common policies, and satisfactory relations with the administration of the dispensary.

Regular meetings of the medical staff or sections thereof should take place for the discussion of professional work. There should be a medical executive committee composed of members of the medical staff, selected by the medical staff, or by the board of trustees on the nomination of the medical staff. The superintendent of the dispensary should be a member of this committee. The total membership of the committee should not be so large as to be unwieldy; seven members is generally the maximum desirable.

4. It is recommended that the board of trustees arrange for periodical conferences of designated members of the trustees, of the medical executive committee, the superintendent and administrative officers such as the heads of the nurses' service, and of the social service department. This joint group should meet periodically for the discussion of dispensary policies or administrative matters.

The following paragraphs refer particularly to dispensaries which are out-patient departments of hospitals.

5. The staff of the dispensary or out-patient department should be appointed according to the principles above laid down, and the physicians serving in the dispensary should receive definite recognition as members of the hospital organization and staff. For each department of the dispensary there should be designated a chief of clinic who should be under the general authority of the chief of the corresponding department of the hospital, but who should be directly consulted by the superintendent or the assistant superintendent who is in charge of the dispensary on all matters affecting the dispensary. The chiefs of the dispensary service should constitute a dispensary medical

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committee which, with the superintendent, the assistant executive in charge, and such others as may be designated, should meet from time to time on dispensary matters. It is suggested that a representative of the dispensary staff be a member of the medical executive committee.

6. It is desirable that the board of trustees of a hospital constitute a special committee, to be known as the dispensary, or out-patient, committee, of its own membership; or, if the board has no sub-committee system, one or more members of the executive committee should be delegated to have special responsibility in connection with the dispensary.

The following paragraph refers to both types of dispensaries.

7. There should be an executive head of the dispensary or out-patient department who, in the case of the dispensary unattached to a hospital, should be the responsible executive officer of the dispensary, and in the case of the out-patient department of a hospital, should have the rank of assistant superintendent of the hospital, and be responsible to the superintendent. He should have authority over all the administrative activities of the dispensary and should meet regularly with the dispensary medical committee and with the dispensary committee of the board, if there be such.

8. The medical staff, acting through the medical executive committee and the superintendent, should formulate a definite set of standards, subject to ratification by the trustees, for all professional work of physicians in the dispensary touching such matters as attendance, the making and supervision of records, diagnosis, use of laboratories, x-ray and other diagnostic aids, the interrelation of staff physicians and outside physicians, etc.

Social Service Department

The following paragraphs relating to the organization of a social service department of a dispensary, are taken from the report of the Committee on Hospital Social Service of the American Hospital Association printed in Hospital Social Service for January, 1921.

9. Organization—(a) As a fundamental general principle, social service should be organized as a department of the hospital, dispensary, or other institution. Assistance or participation by outside individuals or agencies in starting a social service department may well be accepted, but the department should be placed from the beginning, or the earliest possible date, under the complete administrative control of the trustees or other governing authority of the institution. No other arrangement can be deemed permanently satisfactory.

10. This form of organization implies the direct responsibility of the head worker of the department to the superintendent or chief executive officer of the hospital or dispensary.

Dispensary Organization

11. There should be an advisory committee for the social service department appointed by the board of trustees which should include representatives of the following elements: the trustees, the medical staff, professional social workers of standing in the community, non-professional laymen or women with experience or connection with social work or community problems, the superintendent of the institution, the superintendent of the training school; the head worker of the social service department should be an ex officio member of the committee.

This list is intended to be suggestive for the usual hospital organization. Under other circumstances, as, for instance, a social service department connected with a

university, the advisory elements which should be brought together will readily suggest themselves.

12. The social service advisory committee should meet at regular intervals for the discussion of the problems and needs of the department, for hearing reports of its work, and for making recommendations to the trustees regarding the work itself. The trustees or superintendent should look naturally to this committee for aid in determining and guiding this relatively new branch of hospital activity.

13. As to finances, the social service department should be maintained as part of the hospital budget, and its funds, from whatever sources derived, should be administered through the usual hospital procedure. It is desirable that the immediate and overhead expenses of the department shall be so accounted for that its total cost can be readily ascertained, periodically reported, and divided between the hospital and the dispensary services.

REPORT ON VACANT BEDS IN PUBLIC HEALTH SERVICE HOSPITALS

Recent statements that the United States Public Health Service had 4,000 vacant beds in its hospitals while asking for more hospitals has brought out the following reply: "On February 19, the date of our last weekly report," said Surgeon General Cumming, "about 2,200 beds were vacant in our hospitals. Of these, about 1,200 were 'new' beds, in hospitals just opened or in additions to older hospitals; none of them were really in full working order. This leaves about 1,000 vacant beds, or 6 per cent of our total capacity of 17,394. This does not, of course, include our patients in rented beds in contract hospitals, who numbered 10,213.

"Six per cent leeway is a frightfully narrow margin on which to run any hospital; for any day, any hour, the hospital may be swamped by new patients. Particularly is this so in hospitals for soldier patients, a very large per cent of whom are continually asking for discharge or transfer to other hospitals, or leaving without formality. The turnover in our hospitals for the week was 2,274 admitted and 1,785 discharged.

"The six per cent does not of course refer to the same beds or to beds in the same hospital, city, state, or even section of the country. Almost any one of our hospitals may, and not infrequently does, run 20 per cent below on one day and 10 per cent over on the next, with the men sleeping in improvised beds till they can be transferred to other hospitals.

"The situation is made more difficult by the necessity of setting aside twenty out of our fifty-six hospitals for special troubles, twelve for tuberculosis patients, seven for neuropsychiatric patients, and one for epileptics. Such patients are of course not interchangeable.

"Another difficulty arises from the lack of personnel, especially of nurses, the demand for whom is everywhere pressing. In spite of its utmost efforts, the Service has been unable to recruit its corps fast enough to keep pace with the increase in its patients; and it is now about three hundred short. Without nurses, a hospital cannot be efficiently conducted; and the Service is continually being forced, now in this hospital and now in that, to keep down the number of patients or to render insufficient service to all.

"Similar shortage exists in the ranks of its reconstruction aides and its dietitians, all of whom, like its nurses, are women. Lack in these bodies, though not quite so vital, nevertheless means much to the health and the comfort of the patients."

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HINTS TO HOSPITAL SUPERINTENDENTS

IMPROVING THE WALLS AND CEILINGS

Many superintendents who are doleful about the general lack of adaptability of their walls and ceilings to the needs and comfort of patients may welcome a few suggestions for improvisations and additions. If your paint is peeling off—of the operating room, for example—do not make the mistake of trying to make a new coat stick on the old poor coat. Poor paint will never hold good. Remember that the first may have been "patent paint." There is no special surface material to apply, even for operating rooms, in lieu of actually removing the old and putting on completely new layers of good enamel.

There is no cause for lament from managers of hospitals where cement floors already installed are frequently found inconveniently cold to patients' feet. Were the hospital just now in process of construction, with practically every available device to choose from, almost none better than the homely one of supplying rugs could be found. Putting in materials flush with the floor while the building is being constructed has the very grave disadvantage of rendering the wards or rooms impossible of rearrangement, for the beds must always stand in the same place. Small bedside rugs, about three by six feet, answer the need; are sanitary because they can be taken out and cleaned; and give an air of coziness to the ward.

Floors for operating rooms always present the double problem of necessitating a substance which can be quickly and easily mopped and will dry rapidly, but which will be impervious to fluids and micro-organisms. For superintendents who can remodel to some extent the small vitrified white tiles set in cement are the accustomed thing. These are practically impervious, especially when there is a cove base of art marble or terrazzo, the top of which runs flush with the wall surface. But there is absolutely no objection to regular six-foot battleship linoleum for this purpose. It must, of course, be well laid, cemented at every part, with joints sealed to the floor separately from the linoleum, with some very thin cement of shellac first put down. Linoleum in almost any color, fawn or yellow, perhaps, may be used now that administrators are keeping their hospitals clean whether the dirt shows or not.

CARE OF FIRE PUMPS

Fire appliances in hospitals should be kept under constant supervision to insure their working at the proper time. In the case of fire pumps, for instance, it should be ascertained by tests that the pumps are in condition for immediate service. Every pump should be started at least once a week, and water discharged through relief valve or other outlet. In the case of steam pumps, connections and traps should be kept in perfect order, and ample steam should be maintained at all times. In the

case of electric pumps all wiring and connections should be thoroughly examined and tested. Special attention should be given to the heating of pump rooms, the temperature must not be allowed to fall to a point at which there will be danger of freezing. The ends of suction pipes must be kept clear of leaves or other refuse matter which might clog the holes in the strainers. The capacity of a pump may be greatly reduced by such a condition. Suction wells should be cleaned and intake pipes to the wells examined. There should be a good supply of lubricating oil always on hand.

STATE INSTITUTIONS CAN BUY OLEOMARGARINE TAX FREE

Superintendents of municipal, county, state, and government institutions should bear in mind the fact that they can buy uncolored oleomargarine, not subject to special tax or to the stamp tax on the colored product, and color it in the institution. This is made possible by a provision of Treasury Decision 3021, which says, "a state or an individual, who, as the agent of a state, colors or directs the coloration of oleomargarine for use in state institutions, such as asylums, hospitals, penitentiaries, and institutions of like character, is not subject to special tax imposed upon manufacturers of oleomargarine, or to the tax on oleomargarine colored and used in such institutions."

DRILL IS CHEAPER

A certain well-known superintendent was puzzled over frequent requisitions for new bed sheets. An investigation disclosed that many of the nurses were in the habit of making their own caps, gowns and aprons from sheets. His quick wit found a ready remedy for this condition. Instead of indelibly marking the sheets in one corner, the name of the institution, department, etc., was stamped in the center of the sheet. This ingenuity promptly stopped the purloining of the sheets, as a nurse would hesitate appearing in public with the name of the institution in the middle of an apron.

MAKE YOUR OWN DOOR PADS

In November, 1920, THE MODERN HOSPITAL, in its department of "Progress in Equipment and Operation," suggested an attractive kind of door pad, to replace the old fashioned pad of cloth. This new pad was one made entirely of leather, selected to match the color of the doors. There was a noose on one end which slipped over the outer knob, and a thong on the other end slipped over the inner knob. Another satisfactory door pad has been developed by taking worn hot water bottles and ice caps, cutting this rubber into the proper shape, and fastening it onto the door with tapes.

Appetite and Digestibility

No appetite means a slow digestion. What does not "make the mouth water" will not make the gastric juices flow easily. Food must be tempting.

Biscuits, muffins, cake, etc., made with

ROYAL Baking Powder

are both delicious and digestible because of their lightness, due to the strong leavening action of the powder.

They are, moreover, healthful because Royal Baking Powder is made from cream of tartar and adds to food the same wholesome qualities that exist in ripe grapes, from which cream of tartar is derived.

Food made with Royal Baking Powder possesses excellent keeping qualities and fine flavor, stimulating to the appetite and digestion as well.

Royal Baking Powder contains no alum

MEETINGS, CONVENTIONS AND CONFERENCES

OHIO HOSPITAL AND NURSING ASSOCIATIONS TO MEET JOINTLY

THE Ohio Hospital Association, the Ohio Nurses Association, and the Ohio League of Nursing Education will hold a joint meeting in Cleveland, May 16-20. The idea in having this joint meeting is an attempt to combat the growing tendency on the part of a great many of these three groups to divorce themselves from one another. It is felt that a joint meeting in which common problems can be discussed on a common ground may do much toward clearing up the difficulties.

The first two days will be confined to the Ohio Hospital Association, the third day will be a joint meeting with the two nursing groups, and the last two days will be devoted entirely to nursing matters.

On the first day there will be the address of the president, Mr. P. W. Behrens, and an address on hospital records, by Mr. Raymond F. Clapp. Hospital social service will be the subject of addresses on Tuesday, by Miss Malvina Friedman and Mr. Michael M. Davis.

On Wednesday joint problems will be discussed by Dr. A. C. Bachmeyer, Miss Grace Allison, and Mr. H. G. Yearick. The latter two speakers and others will address the meeting during the last two days, which will be concerned with nursing problems.

OHIO HOSPITAL ASSOCIATION PROGRAM.

Monday, May 16, 1921.

Morning Session—10:00 A. M.

Registration.
Meetings of Committees.
Inspection of Commercial Exhibits.

Afternoon Session—2:00 P. M.

President's Address—P. W. Behrens, Toledo Hospital, Toledo.

Report of Secretary—F. E. Chapman, Mount Sinai Hospital, Cleveland.

Paper—"What does Proper Recording of Hospital Per-



MR. P. W. BEHRENS
President, Ohio Hospital Association, Superintendent, Toledo Hospital.

formance Mean, and What are Its Benefits," Raymond F. Clapp, Assistant Director, Welfare Federation of Cleveland.

Discussion—From the Small Hospital's Viewpoint, C. F. Holzer, M.D., Gallipolis. From the Point of View of the Department of Health, H. G. Southmayd, Columbus.

Inspection of commercial exhibits.

Evening Session—8:00 P. M.

Paper—Mr. Creviston of the American Legion.

"The Application of the Minimum Standard and Plans for the Future," Judge Harold M. Stephens, Chicago.

"The Development of the American Hospital Association and the Geographical Sections," A. R. Warner, M.D., Executive Secretary.

Tuesday, May 17, 1921.

Morning Session—9:00 A. M.

Round Table on Administrative Problems—9:00 to 12:00 A. M.

Conducted by Guy J. Clark,

9:00-9:30—Purchasing. Cleveland.

9:30-10:00—Housekeeping. Conducted by Elsie Drugan, Mansfield.

10:00-10:30—Accounting and Records. Conducted by C. B. Hildreth, Cleveland.

10:30-11:00—Mechanical and Laundry. Conducted by Sister St. Simon, Toledo.

11:00-11:30—Dietary. Conducted by Mary A. Jamieson, Columbus.

Afternoon Session—2:00 P. M.

"The Development of Hospital Social Service," Malvina Friedman, Directress of Social Service, Mount Sinai Hospital, Cleveland.

"What is Real Hospital Service," Michael M. Davis, Jr., New York.

Inspection of Commercial Exhibits.

Evening Session—7:00 P. M.

Dinner—Some prominent speaker on an unrelated subject.

Wednesday, May 18, 1921.

Morning Session.

New Business.

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Bridgeburg, Ont.



MISS LAURA LOGAN
President, Ohio State Association of Graduate Nurses, Principal of
the School of Nursing, Cincinnati General Hospital.

Report of Audit Committee.
Report of Resolution Committee.
Report of Committee on Time and Place.
Report of Nominating Committee.
Election of Officers.
Adjournment.
10:00—Joint Meeting with Ohio State Association of Graduate Nurses.
"The Necessity for Correlated Effort in Hospital Administration," A. C. Bachmeyer, M.D., Superintendent, Cincinnati General Hospital.
Discussion—From the Principal, Grace E. Allison, R.N., Lakeside Hospital. From the Superintendent, H. G. Yearick, City Hospital, Akron.

Afternoon Session—2:00 P. M.

Round Table on Correlated Hospital and Nursing Problems.

2:00 to 3:00—E. R. Crew, M.D., Superintendent, Miami Valley Hospital, Dayton.
3:00 to 4:00—Daisy Kingston, R.N., City Hospital, Fremont.

PROGRAM OF OHIO STATE ASSOCIATION OF GRADUATE NURSES.

Wednesday, May 18, 1921.

Joint Session with Ohio Hospital Association.
10:00 A. M.—Paper: "The Necessity for Correlated Effort in Hospital Administration," A. C. Bachmeyer, M.D., Superintendent, Cincinnati General Hospital.
Discussion—From the Principal, Grace E. Allison, R.N., Principal, Lakeside Hospital School for Nurses, Cleveland. From the Superintendent, H. C. Yearick, Superintendent, Akron City Hospital.
2:00 P. M.—Round Table on Correlated Hospital and Nursing Problems:
2:00 to 3:00—E. R. Crew, M.D., Superintendent, Miami Valley Hospital, Dayton.
3:00 to 4:00—Daisy Kingston, R.N., Superintendent, Memorial Hospital, Fremont.
7:45—Meeting of Board of Trustees, Ohio State Association of Graduate Nurses.

8:45—Advisory Council Ohio State Association of Graduate Nurses.

Thursday, May 19, 1921.

8:00 A. M.—Registration.
8:30—Executive Committee, League of Nursing Education.
9:00—Business Session, State Association.
11:00—Business Session, League of Nursing Education.
12:00—Registration.
1:30-3:30 P. M.—Private Duty Section.
Paper: Private Duty Nursing from a Layman's Point of View.
Paper: Private Duty Nursing from a Physician's Point of View.
Discussion.
3:30—Tea at the Nursing Centre, followed by an automobile ride over the city.
8:15—General Session.
Music by Nurses' Chorus.
Address of Welcome: Mrs. John H. Lowman, Cleveland.
Response: Laura E. Logan, R.N., President, Ohio State Association of Graduate Nurses.
Response: Claribel A. Wheeler, R.N., President Ohio State League of Nursing Education.
Paper: Relation between Medical and Nursing Professions.
Paper: Relation of a School of Nursing to the Hospital.
Paper: Relation of the Nurse to the Public, James E. Cutler, Dean of School of Applied Social Sciences, Western Reserve University.

Friday, May 20, 1921.

8:00 to 9:00 A. M.—Round Table: Instructors in Home Hygiene, conducted by Jean Anderson, R.N., Director, Bureau of Instruction, Lake Division, American Red Cross.
8:30—Registration.
9:00—League of Nursing Education.
Paper: "Health and Recreation of Student Nurses," Lillian Hanford, R.N., Principal, Miami Valley Hospital School for Nurses, Dayton.



MISS CLARIBEL A. WHEELER
President, Ohio State League of Nursing Education, Principal, Mount Sinai School for Nurses.

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- No. 845 Nurses' Operating Gowns. White Duretta Cloth. New price, per doz...\$18.00

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(Small, Medium, Large)

- No. 28 Pepperell Cloth, double yoke front; wide hems and tapes in back; open all way down. 36 in. long; long sleeves. New price, per dozen.....\$13.50
- No. 128 Indian Head. Same style as No. 28. New price, per dozen.....\$13.50

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Discussion: Laura Grant, R.N., Principal, Cleveland City Hospital School for Nurses.

Paper: "State Board Examinations," Ida May Hickox, R.N., Chief Nurse Examiner, Ohio.

Discussion: June Ramsey, R.N., Assistant Principal, Lakeside Hospital School for Nurses, Cleveland.

Paper: "Factors which determine the Equivalent to a High School Education," Mrs. Norma Selbert, R.N., Assistant Professor of Public Health Nursing, Ohio State University.

Discussion: Melisse Wittler, R.N., Superintendent of Nurses, St. Luke's Hospital School for Nurses, Cleveland.

11:30—Play Hour.

12:00—Registration.

1:30 P. M.—Public Health Section.

1:30-3:30—Round Table: School Nursing in Urban and Rural Districts, Ethel Osborn, R.N., Superintendent of School Nurses, Cleveland; Alice Squire, R.N., Red Cross Public Health Nurse, Lucas County.

1:30-3:30—Round Table: Industrial Nursing, Caroline Hilliard, R.N., Superintendent of Nurses, Goodrich Tire and Rubber Co., Akron, Ohio.

3:30—Closing Business Session State Association.

4:30—Closing Business Session League of Nursing Association.

8:15—Public Health Section.

8:15-9:15—Round Table: Nutritional Classes for School Nurses, Vivian Reamer, B.Sc., Household Educator, Toledo District Association.

9:30-10:30—Round Table: Tuberculosis Nursing, Cora M. Templeton, R.N., Director of Nurses, Department of Health, Cleveland; Cora Schmees, R.N., Public Health Nurse, Hamilton County.

ILLINOIS ASSOCIATION DISCUSSES NURSING PROBLEMS AND HOSPITAL RECORDS

The annual meeting of the Illinois Hospital Association was held in Chicago, on March 18. After the reading of the minutes by the secretary, Dr. E. T. Olsen, the president, Dr. M. L. Harris, made a report of the activities of the Association during the past year. Various meetings of the executive committee were held to consider matters which came up from time to time. Among them were questions concerning the intern year, and also the rules regulating training schools for nurses. The president and the secretary of the Association, at a conference with the Governor of Illinois, the Director of the Department of Registration and Education, and the Superintendent of Registration, presented the arguments of the hospitals against certain rules of the Department of Registration and Education, with the result that the following changes in the rules were made. Hospitals may conduct a two year training course for nurses. The Department cannot require a "qualifying certificate" except when the nurse is applying for registration. The Department cannot require graduate nurses employed by hospitals as superintendents of nurses, supervisors, or in any other capacity, to be registered, nor can it set the educational requirement of one year of high school work except as a qualification for registration. There will be in the diplomas of those graduates who have not fulfilled this educational requirement a clause to the effect that the graduate is not qualified for registration at that time. The clause will read simply, "Registration qualifications incomplete," on in a similar way, so as not to reflect on the nurse or the training school from which she is graduated. The Department cannot discriminate against schools graduating such nurses. The minimum curriculum requirement of 325 hours was excluded from the rules, as it was obvious that the same number of hours could not be required for two years as for three years of training. The Association established a minimum of 235 hours for the two years course, which has the approval of the Illinois State Medical Society.

The secretary then made a report of work done during the year. A questionnaire was sent out to the hospitals of the state for the purpose of collecting some information on the question of the two year training course. Answers were received from only sixty-three hospitals; of these, twenty were conducting a two year course, thirty-eight a three year course, two were organizing schools, and three were without training schools. Of the three year training schools, only five had a sufficient number of nurses, and of those five, three were having difficulty in keeping enough. Of the schools having two year courses, ten had their full number of pupils, and only one was having difficulty in keeping up its supply. It was found from the questionnaire that the cash and other allowance made to nurses had apparently no effect on the number of pupils attracted to the school.

A general discussion followed, the chief part of which was concerned with hospital records. Various questions were opened up as to why records are kept; are they kept for the protection of the hospital only; has the hospital a right to give out information from these records; if not, who has the right—the physician or the patient; the advisability of keeping the old fashioned "full record," or cutting it down to the short record, confined to points bearing directly on the case; the question of whether the physician or the intern should keep the record, and if the latter, how the physician can be persuaded to read it over. Dr. C. U. Collins of Peoria proposed a resolution to the effect that the Association believed the hospital has a right to a sufficient record to protect itself; Dr. Pettit of Ottawa suggested that the hospital be defined from the legal and ethical standpoint.

President Harris gave his view of the legal status of the question of histories; the patient, in his judgment, has the only right to the history, or to give out information concerning it; when the physician receives the history from the patient it is strictly confidential. The hospital is entitled to keep a record of what is done to or for the patient while in the hospital, for which the hospital is responsible, including a record of the patient's entrance and departure, setting forth condition, results, etc. It was decided that the resolution had been framed too hastily, and it was withdrawn. Dr. Collins then made a motion that a committee be appointed by, and including, the president to draw up a resolution defining the rights of the hospital in the question of record keeping. The motion was carried.

The following officers were elected for the year 1921: President, Dr. M. L. Harris; vice-president, Dr. William L. Noble; treasurer, Dr. C. O. Young; secretary, Dr. E. T. Olsen; trustees, Mr. William J. Rathje, Chicago; Dr. Emil Ries, Chicago; Dr. Martin M. Ritter, Chicago; Dr. C. U. Collins, Peoria; and Dr. J. H. Franklin, Spring Valley.

WISCONSIN HOSPITAL ASSOCIATION ISSUES TENTATIVE PROGRAM

The next meeting of the Wisconsin Hospital Association will be held in Kilbourn and Walker Halls, Milwaukee Auditorium, May 25 and 26, 1921. The tentative program follows:

Invocation.

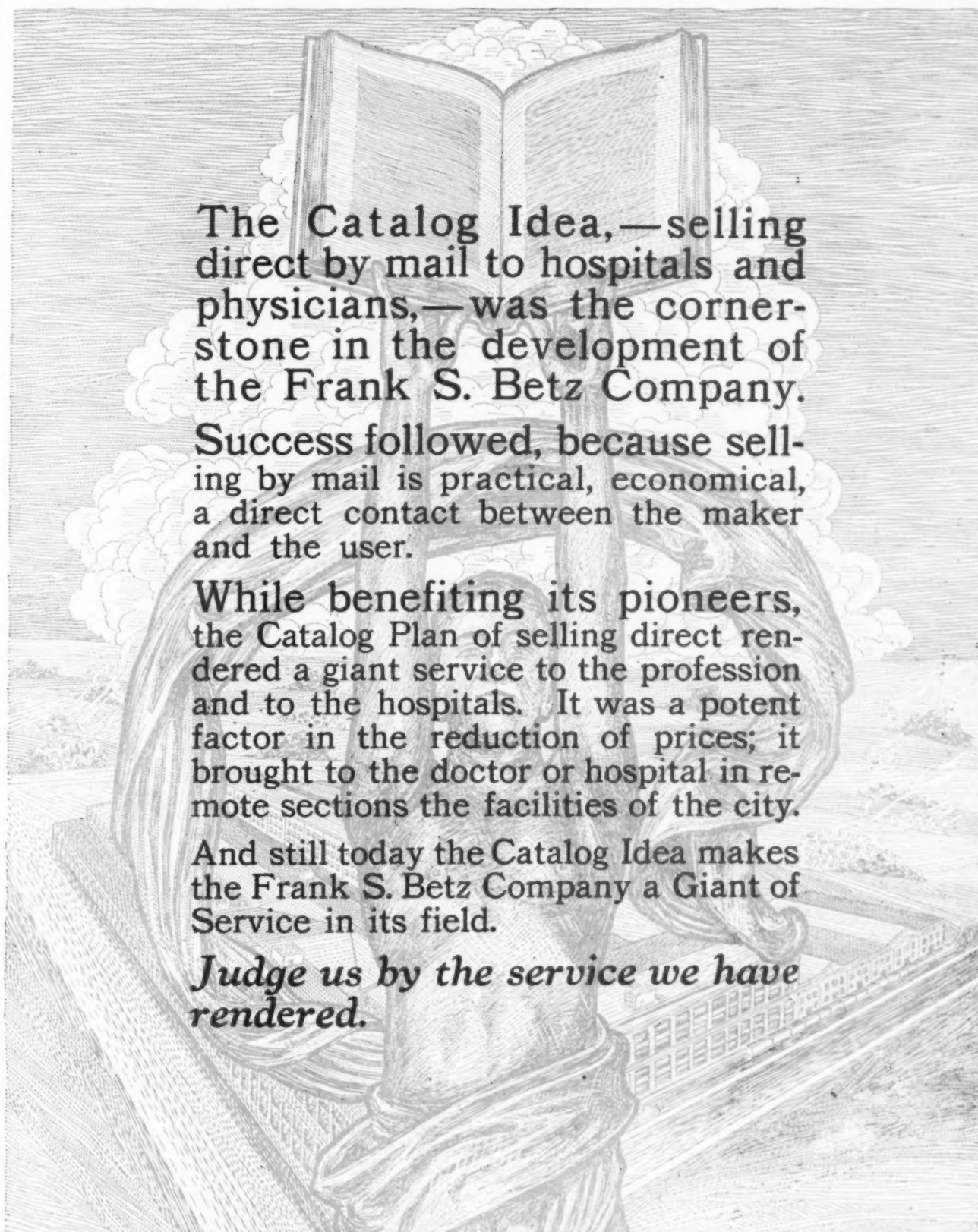
Address of Welcome.

President's Address.

Report of Executive Secretary and Treasurer.

Unfinished Business.

Problems of the Training School—Sara Parsons, R.N., Kansas City, formerly superintendent of nurses, Massa-



The Catalog Idea,—selling direct by mail to hospitals and physicians,—was the cornerstone in the development of the Frank S. Betz Company.

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chusetts General Hospital. Now making a survey of the training schools of the State of Missouri.

Discussion.

Adjournment, 12:30.

GROUP LUNCHEONS—12:30 TO 2:00

Hospital Executives, University Club.

Training School Executives, City Club.

Dietitians and Stewards, Milwaukee Athletic Club.

Anesthetists, City Club.

AFTERNOON SESSION—2 P. M., WALKER HALL

The Anesthesia Problem of the Hospital—Isabella C. Herb, M.D., Rush Medical College, Chicago.

Discussion.

Financial Management of the Hospital—Frank E. Chapman, superintendent, Mount Sinai Hospital, Cleveland, Ohio.

The Institutional Laundry—Innovations and Economies—W. T. Williams, editor of the National Laundry Journal, Chicago.

Hospital Architecture, with Special Reference to Interior Arrangement—Perry W. Swern, of Berlin, Swern and Randall, Chicago.

Discussion—Frank E. Chapman.

Adjournment.

BANQUET—7 P. M., HOTEL PFISTER

This banquet will be attended by the members of the association, and it is especially desirable that hospital trustees and other lay people interested in hospitals be present.

Speaker of the evening—William J. Mayo M.D., Mayo Clinic, Rochester, Minn.

THURSDAY MORNING, MAY 26, 9 A. M.

Election of Officers.

Reports of Committees.

Address by representative of the American Hospital Association.

Address by representative of the American College of Surgeons.

Recent Advances in Occupational Therapy—Russell Bird, director of crafts, Wisconsin Psychiatric Institute, Mendota, Wis.

Round Table on Hospital Administration—Conducted by Asa Bacon, superintendent, Presbyterian Hospital, Chicago, treasurer of American Hospital Association.

Assisting Mr. Bacon—Amelia Olson, R.N., Luther Hospital, Eau Claire; S. M. Smith, M.D., Hanover Hospital, Milwaukee; H. K. Thurston, Madison General Hospital, Madison; Miss Schoolbred, R.N., Ashland Hospital, Ashland; Hannah Paulson, R.N., Wisconsin Deaconess Hospital, Green Bay; Mrs. G. A. Hipke, Milwaukee Maternity and General Hospital, Milwaukee; Sister M. Seraphia, C.S.A., St. Agnes Hospital, Fond du Lac; J. W. Coon, M.D., River Pines Sanatorium, Stevens Point; J. K. Goodrich, M.D., River View Hospital, Wisconsin Rapids; Agnes Reid, R.N., Bradley Memorial Hospital, Madison, Wis.; J. H. Bauernfreund, M.D., Monroe; Ella B. Smith, Wausau.

Adjournment.

LUNCHEON

AFTERNOON SESSION—2 P. M., WALKER HALL

Medical and Hospital Program of the University of Wisconsin—C. R. Bardeen, M.D., dean of University Medical School.

The Outdoor Department—How It Can Best Serve the Community and the Hospital—John E. Ransom, superintendent, Michael Reese Dispensary, Chicago.

Discussion.

Outline of Efficient Case Record System, Applicable to Both Small and Large Hospitals—E. Moerchen, record clerk, St. Joseph's Hospital, Milwaukee.

Discussion.

The Status of the Dietitian—Necessary Qualifications and Training—Prof. L. D. Harvey, president, Stout Institute.

Adjournment.

NATIONAL TUBERCULOSIS ASSOCIATION WILL MEET IN NEW YORK

The seventeenth annual meeting of the National Tuberculosis Association will be held at the Waldorf-Astoria, in New York City, June 14, 15, 16, and 17, 1921. The meeting will be immediately following that of the American Medical Association, at Boston, and preceding that of the National Conference of Social Work, to be held in Milwaukee beginning June 22.

The chairman of the advisory council is Dr. Haven Emerson, Washington, D. C. Some of the other sections and their chairmen are: the clinical section, Dr. James A. Miller, New York City; the pathological section, Dr. Simon Flexner, New York City, there will be a joint session of the clinical and pathological sessions; sociological section, Dr. George Eaves, Birmingham, Ala.; nursing section, Miss Mary A. Meyers, R.N., Indianapolis. The American Sanatorium Association, of which Dr. Lawrason Brown, Saranac Lake, N. Y., is the president, will meet on June 14; the National Conference of Tuberculosis Secretaries, of which Dr. Edward Hochhauser, New York City, is the president, will meet on June 15.

CATHOLIC HOSPITAL ASSOCIATION TO HOLD 1921 CONVENTION IN ST. PAUL

The sixth annual convention of the Catholic Hospital Association of the United States and Canada will be held at St. Thomas College, St. Paul, Minn., June 21, 22, 23, and 24. The duration of the convention has been increased to four days in order to allow more time for conferences, of which there will be fourteen, representing the various phases of hospital activity. An entire day, Thursday, June 23, will be devoted to these, and the morning session of Friday, June 24, will be given up to reports and discussions of the work accomplished by the different conferences of Thursday. One session of the convention will consist of papers and discussions that will be of special interest to the hospital doctors. The enthusiasm thus far manifested indicates a record attendance and important accomplishments for still further progress in the Association's plans.

OKLAHOMA HOSPITAL ASSOCIATION ANNOUNCES PROGRAM

The Oklahoma State Hospital Association will meet at McAlester, on May 18, 1921. There will be an address by the president, Dr. Fred S. Clinton, Tulsa, Okla., an address by Dr. C. M. Rosser, professor of surgery, Baylor University College of Medicine, Dallas, Texas, on "More Hospitals, Bigger and Better Hospitals, a Health Necessity," and one by Dr. LeRoy Long, dean and professor of Surgery, Oklahoma University Medical College, Oklahoma City, "Some Remarks on the Functions of the Hospital."

Danville State Hospital for the Insane, Danville, Pa., is contemplating the addition of a nurses' home to cost about \$40,000, and an infectious disease hospital to cost \$45,000.



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QUERIES AND ANSWERS

INFIRMARIES AND ALMSHOUSES

To the Editor of THE MODERN HOSPITAL:

Shall almshouses be conducted as infirmaries so as to solve the problem of a place for the "chronics," utilizing the inmates for the care of the others, with medical and nursing supervision? It is becoming impossible to hire employees to care for such objectionable cases.

SUPERINTENDENT OF AN ISOLATION HOSPITAL.

THE MODERN HOSPITAL referred this question to the deputy commissioner of charities and corrections of Westchester County, New York, who says: "There are so many elements to this question that it cannot be properly answered by a mere 'no' or 'yes.'"

"When the new county home in Westchester, N. Y., was planned, arrangements were made for six wards for chronic hospital patients that would accommodate about one hundred and forty. These infirmary wards had all the modern hospital equipment facilities. About the first of November we shifted the almshouse and hospital population so now the infirmary wards have become part of the General County Hospital. The shift was made in order to use the new and better equipped building for the rapidly increasing hospital demands of the county, since we found the old hospital plant quite adequate for the somewhat depleted population of the county home, excluding the infirmary patients.

"I. Our experience has convinced us that infirmary patients, if housed in properly equipped wards in connection with the home, can be more economically maintained than as a part of a general hospital. This is because the home always affords considerable labor that can be utilized in many ways, which makes unnecessary the employment of as many paid people as are required when the infirmary becomes part of the hospital, and there is none of this labor available.

"II. In actual practice I think it will be found more difficult to maintain desirable standards of caring for the infirmary patients when their wards are part of a home, since there is an inevitable tendency to utilize almshouse labor, which is often very inferior and not dependable. Such an arrangement also tends to make the public feel that the infirmary is for patients primarily because they are dependent, whereas it is more desirable to have the public realize that an infirmary is more useful if it is understood that people go there because they are sick and infirm rather than because they are dependent. We have found quite a demand for infirmary service from people who do not want to accept charity but cannot afford to pay over two dollars a day, and frequently much less. In normal times, infirmary service can be furnished in a large unit for from seven to ten dollars a week.

"III. In operating an infirmary as part of a general hospital, I find a tendency among the doctors to give their time to the surgical and acute cases to the extent of

sometimes approaching neglect of these chronic cases. It is difficult to maintain enthusiasm among the hospital staff for this chronic service.

"IV. While it will probably cost more money to maintain infirmary service in connection with the hospital, I do think such arrangements very advantageous, since it affords the infirmary patients all the facilities of hospital service in the way of laboratories and x-ray equipment, and some attention from a visiting staff. It is easier to maintain a higher standard of service in the hospital where the whole organization has the idea of caring for the sick. In an almshouse or home the staff is less apt to be interested in medical treatment than in maintaining an acceptable appearance as a home.

"In summarizing, I wish to assure you that infirmaries can be well conducted in either a home or hospital, since, as usual, it all depends upon the management. As a general principle, however, I think that incorporation of infirmaries as a part of a general hospital will work out to the advantage of the patients, although they will probably cost a little more."

EXTERMINATING VERMIN IN CREVICES

To the Editor of THE MODERN HOSPITAL:

As we are about to have the interior of our building painted, could you suggest what chemical or poison might be mixed with the paint to help in the complete extermination of flies and other pests found in cracks and crevices?

MEDICAL DIRECTOR AND SUPERINTENDENT.

We have secured authoritative information that there are no chemicals at the present time that would be of any value in a paint to help in the extermination of flies and other pests. However, inasmuch as an air-tight film forms over any object that is painted, we believe that, in itself, would exterminate any vermin present and it should not be, therefore, necessary to use an exterminator.

There is a hygienic calcimine containing chemicals which exterminates all kinds of vermin and creates a sanitary condition wherever it is used. It comes in the form of a dry powder and is dissolved in hot water.

FOOD SERVICE FOR NURSES

To the Editor of THE MODERN HOSPITAL:

Do you consider the cafeteria system for nurses desirable?

HEAD OF NURSES' HOME.

Cafeteria service for nurses is far better than mediocre maid service, but we cannot believe that cafeteria service three meals a day, three hundred and sixty-five days a year, is a desirable thing in a nurses' home. There is no question that it is economical in food and service. We believe the nurses like it better than the average service given in a nurses' dining room, but if they were asked to choose between waitress service or cafeteria service, there is no question in our mind as to which they would choose.

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BOOK REVIEWS AND CURRENT HOSPITAL LITERATURE

CLEVELAND STUDIES ITS HOSPITAL AND PUBLIC HEALTH FACILITIES*

CONSTRUCTIVE SUGGESTIONS FOR HOS- PITALS AND DISPENSARIES

By JOHN E. RANSOM, Michael Reese Dispensary, Chicago, Ill.

The purpose and scope of this study of hospitals and dispensaries, which comprises Part 10 of the Cleveland Hospital and Health Survey, is stated by the author as: "an endeavor . . . to review the details of the work of the hospitals and dispensaries of the city, in their medical, administrative, and financial aspects, and to consider also the relation of these institutions to the various sections of the public which use them or need to use them." A quantitative appraisal of Cleveland's hospital facilities showed that, in relation to the population served by its hospitals, it has two and eight-tenths hospital beds per 1,000 population, falling far below New York, Boston, and other large cities. There are still greater inadequacies in provision for special types of patients and for children. Geographical distribution of hospitals and dispensaries showed the same lack of early planning as is found in most centers of population.

Many hospital needs, most of which are not peculiar to Cleveland institutions, are noted. Among these are the need for greater public interest in publicly controlled medical institutions, more nurses, especially in public hospitals, greater wisdom in the selection of members of boards of trustees, better records and statistics, better publicity, greater appreciation of the fact that unless the hospital obtains the cooperation of the patient it usually fails to give him its best service or to secure for itself the best response from the community of which the patient is a member.

In relation to the work of Cleveland's dispensaries or out-patient departments, the Survey makes the following general statement of needs: (1) more work to be done; (2) better executive direction through the assignment of a definite officer to be in charge of the dispensary, under the superintendent; (3) representation of the out-patient department so as to secure better recognition of it by the hospital authorities; (4) paid assistants for the medical staff (social workers, nurses, clerks,) so as to relieve the physicians of non-medical drudgery and improve the grade of service to patients; (5) better records, which would largely be accomplished by the assistants just mentioned; (6) better plants and equipment. Cleveland, like

most other cities, suffers from lack of any general plan for dispensary service. The different clinics are not co-ordinated with one another or with the public health and charitable agencies. It is essential to have a plan, and effective organization, whereby the work of existing dispensaries shall be improved and the new dispensaries be established in sections of the city now unprovided for. But above all, the aim must be to furnish a basis upon which dispensary service should be better understood by the community and better serve the community."

How well are here set forth the almost universal needs of these very important (at least potentially important) medical institutions!

A special study of Cleveland's need for convalescent service, and its facilities for meeting that need, brought forth the following significant conclusions: "Visits to two hundred patients discharged from the wards of Cleveland hospitals showed 87.5 per cent in home environment unfavorable for convalescence. In two-thirds of these homes, conditions were remediable if adequate and adaptable social service could be supplied. This service is almost entirely lacking at present. In one-third, conditions were not remediable, and care in a convalescent home was needed. With present resources it is impossible to meet this need. The hospital faces a choice of evils, it must either retain the patient, using a bed needed for a case of acute illness, or return the patient to a home unfitted to complete the cure."

Lack of facilities for the care of the chronically ill has at least two serious results. One is the use of costly hospital facilities for their care, thus diminishing the facilities available for the acutely ill. The other is the lack of adequate care for large numbers of chronic patients who must be cared for outside of medical institutions.

Perhaps the greatest value existing in this noteworthy study of a city's institutional medical equipment lies in the fact that it is constructive. True, there were found many defects of organization and method. But the Survey is not content with bringing these to light, it gives the major part of its attention to the presentation of policies and plans by which these institutions may with greater efficiency serve their community. Because the conditions found could in many instances be found in any sizeable city, and because the plans for bettering these conditions are mainly universally applicable, this study is an extremely valuable and timely contribution to our literature on medical institutions in relation to community need.

*This is the second group of reviews of the different sections of the Cleveland Hospital and Health Survey, which are appearing in THE MODERN HOSPITAL. The first group, published in the April issue, were reviews of the Nursing Section, the Child Health Section, and the Tuberculosis Section.

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Page 413

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CLEVELAND'S PUBLIC AND PRIVATE HEALTH AGENCIES

By OTTO R. EICHEL, M.D., Albany, N. Y.

The Report on the Survey of Public Health Services and Private Health Agencies of Cleveland, is Part II of the Hospital and Health Survey recently conducted by a group of public health experts at the request of the Cleveland Hospital Council.

The report of the general survey includes eleven parts. Section 2, with which this review deals, is Part II, and is in turn presented in four parts.

Part I, the introduction, outlines Cleveland's Municipal Government, giving also a brief statement of the history, evolution, and present functions of the Welfare Federation, of which the Hospital Council is a member. One statement of special interest explains that, "roughly speaking, about twice as much money is raised for the services included under health preservation to be spent by private agencies annually in Cleveland as is appropriated by the civil government for this group of functions"; this necessitates the raising of two health budgets from the same group of people, one voluntary self-taxation, and the other compulsory taxation. It indicates, however, the public spirited qualities of Cleveland's citizens.

Part II gives an exhaustive review of the city's public health service, describing the division of health, which is part of the Department of Welfare. One by one the functions and accomplishments of the division's various bureaus are described; these are the bureaus of communicable disease, district physicians, sanitation, food and dairy inspection, milk control, and vital statistics. The new activities proposed for the division are institutional inspection, industrial hygiene, medical examination for city employees, public health education, and the control of drug addicts. The section concludes with a description of Cleveland's health centers and the coroner's service.

It is apparent that many of the weak features in Cleveland's health administration might be prevented if the health commissioner were a full time official with a compensation sufficient to enable him to devote all his time to the study, developing, and perfecting of his department. Proper educational public health publicity would undoubtedly aid in correcting this situation, but it appears that the position of research and publicity director has never been filled.

The indifference to conformance with Civil Service requirements in the matter of appointments, indicates a failure to recognize a necessary standard of competence and efficiency in filling positions. In addition, no physical examinations are given applicants, and no efficiency rating to employees. All of these circumstances naturally reflect throughout the service, in its administration and general morale.

An inadequate budget for this division may also be one of the reasons for some of its lack of efficiency, forty-seven cents per capita having been appropriated for 1920, in comparison with Detroit's 71.4 cents per capita.

Indiscriminate districting of the city by the various branches of the division must also contribute to the inefficiency of the city's health activities. The prevalence of smallpox, which is so extensive that practically all the time of the communicable disease bureau has been devoted to its control, appears to be due to the existence of large unvaccinated groups of people in various areas, and recently more particularly to the influx of Southern negroes. Just why these unvaccinated areas exist is not explained, but their existence is probably the result of the deficiencies in health administration already referred to.

The bureau of sanitation, for several years without a

director, is conducted by a sanitary squad of police, without the necessary training to intelligently administer their work. Privy vaults, prohibited in most cities of the size of Cleveland, are not only permitted, but are often found in shocking condition.

Inadequate control of milk supplies through lack of city ordinances appears to be evident.

Cleveland has an extensive "patent medicine problem." The city is to be congratulated upon the important activities being undertaken to remedy this evil, although no notable reform has yet been accomplished.

Vital statistics, so absolutely basic in public health work, are "non-existent" in the city of Cleveland, according to Dr. Dublin. A glance at the budget shows an appropriation for 1920 of \$7,029 for salaries for such a bureau, but no results of any value are obtained for this expenditure. No monthly records of births, deaths, or cases of communicable disease are available. The recommendations on vital statistics incorporated in the report would do much, if adopted, to increase the efficiency of the city's public health activities; these recommendations constitute a sound manual for the work of registration.

Part III deals with the private health agencies of the city, for which is expended, it will be remembered, twice the amount of money appropriated by the municipality for the protection of the health of its citizens. These include the Anti-Tuberculosis League, the Visiting Nurse Association, the Day Nursery, the Free Kindergarten Association, the Hospital Council, the Society for the Blind and a Program for the Prevention of Blindness, the Associated Charities, the Association for the Crippled and Disabled, and a program for the care of cripples, ending with the description of the proposed agencies and programs for the prevention and relief of heart disease, and prevention and cure of cancer.

The constructive and preventive value of these agencies appears to be due fundamentally to their affiliation with the Welfare Federation, preventing unnecessary duplication of effort and affording an opportunity for each organization to concentrate all its efforts on the phase of health work for which it was established.

The efforts of the Cleveland Society for the Blind in promoting model legislation for sight saving are particularly commendable. Although it is evident that much attention is being given to the cure of cripples, there appears to be lack of centralized effort in carrying out the various programs.

In Part IV, the report closes with the summary of recommendations of the Survey. These rightfully call for full time heads of divisions and bureaus, the development of an educational publicity bureau, the districting of the city according to the census tracts or sanitary areas, and a more intensive administration of both the public health services and the private health agencies.

THE CLEVELAND HOSPITAL AND HEALTH SURVEY—VENEREAL DISEASES

By JOHN H. STOKES, M.D., Mayo Clinic, Rochester, Minn.

It is estimated that approximately from 8,000 to 10,000 patients are annually treated for venereal disease in Cleveland, and that at least 30,000 of the population have the disease. This would seem to be a very conservative estimate. During the last six months of 1919, 1,654 cases of syphilis and gonorrhea were reported, which forms a rather small proportion of the estimated number observed.

Attention is directed in this report to a defect in diagnostic service which is all too common in municipal serologic laboratories, in that the temporary services of a

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college student on a part time basis are all that is available for the performance of the Wassermann test. The available hospital facilities are, as in other cities, totally inadequate. Seventy-five beds for syphilis and fifty for gonorrhea at the City Hospital, with the addition of a negligible number at the Lakeside Hospital, constitute the entire provision. It is practically impossible for a venereally infected person, willing and able to pay, to be admitted to any other hospital in Cleveland for gonorrhea or syphilis in the communicable stages.

One notes among the recommendations a suggestion that physicians prepare their offices and dispensaries to give medical prophylaxis for venereal disease, and to maintain contact with exposed persons thus treated. The establishment of a diagnostic center at the so-called Government Clinic is urged. It is suggested that this center receive all types of patients but that it refer to private physicians all applicants that can pay; and that it serve as a center to which physicians may send their patients for diagnostic assistance. This is an important step in the direction of public health centers for the advisory control of diseases requiring special equipment and expert service for their management. The work of the syphilological clinic at Lakeside Hospital and that of the venereal clinic at Mount Sinai Hospital is commended. The management of gonorrhea at several of the dispensaries is severely criticized on the ground of lack of privacy, follow-up, and education of the patient. The estimate of 150 beds as necessary to make the service of the municipal hospital effective seems conservative for so large a city.

The organization of a venereal disease bureau in the municipal division of health is recommended, thus extending to the municipality a plan of organization now in force in the separate states. To this bureau are assigned the organization, supervision and stimulation of treatment facilities, follow-up, and public education. It is advised that the chief of this bureau be a full time officer, not permitted to do clinical work, a recommendation which seems to us open to criticism on the ground that active contact with the medical problems of syphilis and gonorrhea gives to an administrative officer the necessary touch of practicality which is essential to the best cooperation and the highest scientific work. Such contact with clinical matters, however, should not imply swamping the official with routine treatment duty.

In the section on follow-up we note samples of the so-called "simple request cards" for follow-up, whose peremptory, mandatory tone is anything but an inspiration to cooperation. Too many social workers, in this field especially, evidence a disposition to regard follow-up as necessitated by the inherent delinquency of the patient, rather than by the actual demands of treatment. It is precisely this mandatory tone which gives to public dealings with the patient their distinctively disagreeable flavor.

In the section on law enforcement a very wise comment is passed upon the value of separating the problems of detection, diagnosis, and treatment of venereal disease, from the detection, diagnosis, and treatment of delinquency. Recent writers on police problems have emphasized the weakening of the effectiveness of the police by the distribution of their energies over fields which should be under other jurisdiction. While Cleveland is in general well equipped with laws and administrative machinery for the management of delinquency, it is recommended that much of the routine inspection of hotels, dance halls, and so forth, be conducted by a special women's bureau in the police department. It is further urged that the proper time for protective and probation

work in the municipal courts is after the arrest, but before the trial or conviction of the offending girl. The establishment of a women's court and a finger print system of identification of all convicted sex delinquents is urged, the latter item to cost \$2,500. The suggestion that any intelligent policeman can be taught to operate it, seems to need elaboration.

With reference to vice conditions, Cleveland has no red light district or public houses of prostitution. Little soliciting was being done on the streets, and the dance halls were not apparently being used for this purpose. The situation of many of the hotels, however, was inexcusably bad. Chauffeurs and taxicab stands are active parties to prostitution. The "Golden Rule" in the Cleveland Police Department is blamed for much of the laxity, and the attention of the city departments is invited to the new state law which eliminates fines for prostitution and provides for long sentences. The section on sex education contains no particularly new material.

SHORT TALKS ON PERSONAL AND COMMUNITY HEALTH

By Louis Lehrfeld, M.D. Agent for the Prevention of Disease, Department of Public Health, Philadelphia.¹

The talks included in this volume are designed primarily for use in schools and for the social worker. They cover a wide scope of public health work and are written in simple language. The discussion of each subject is short and free from technical terms, yet the points essential for proper consideration of its relation to health are well covered. A particularly good instance of this is in the concise but convincing reasons given under the heading "Why You Should Not Spit."

The first section of the book is devoted to preventable diseases and how to avoid them. The author makes no pretense of offering new facts or ideas for one who is familiar with health activities, but he has given us a book that will be a valuable help in teaching school children, foreign workers in industrial centers, and other groups, how to promote health in their community, as well as giving instruction relative to their personal health and habits.

SOCIAL SERVICE NECESSARY

"It is timely to say that not a year passes without the readmission of patients who have been unable to maintain their readjustment to life outside. It is of the essence of what is commonly called "insanity"—an ugly word, of which we of Butler Hospital fight shy—that it connotes that degree of mental impairment which so involves the intellectual and emotional reactions of the sick individual that his language or conduct is inadequate to or inconsistent with his previous standard, inasmuch that customary social contacts and *sustained self-adjustment* to his surroundings become difficult or impossible. It comes about, in the case of a fairly large number of our readmissions, that the patient has broken down under stress in the home environment, perhaps owing to the type of occupation taken up, or on account of failure to heed signals to 'stop, look and listen,' the importance of which had been pointed out to him at the hospital as a warning before his discharge. The fact is, at all events, that resistance often breaks down earlier by reason of causes that would seem avoidable under a proper system of after-care such as a trained social worker might furnish under the aegis of the hospital.—1920 *Superintendent's Report, Butler Hospital, Providence, R. I.*

1. F. A. Davis Company, Philadelphia, Pa., Publishers.